

No. 88-2043-CFX
Status: GRANTED

Title: L. Douglas Wilder, Governor of Virginia, et al.,
Petitioners
v.
Virginia Hospital Association

Docketed:
June 15, 1989

Court: United States Court of Appeals
for the Fourth Circuit

Counsel for petitioner: Chaffe, Roger L.

Counsel for respondent: Donlan Jr., Martin A.

Entry	Date	Note	Proceedings and Orders
1	Jun 15 1989	G	Petition for writ of certiorari filed.
2	Jun 22 1989	D	Application (A88-1035) for a stay pending disposition of the petition for a writ of certiorari, submitted to The Chief Justice.
3	Jun 26 1989		Application (A88-1035) denied by the Chief Justice.
4	Jul 14 1989		Brief amici curiae of Alaska, et al. filed.
5	Jul 19 1989		Brief of respondent Virginia Hospital Assn. in opposition filed.
6	Jul 19 1989		DISTRIBUTED. September 25, 1989
7	Oct 2 1989		Petition GRANTED. limited to Question 1 presented by the petition.
8	Oct 23 1989	D	***** Application (A89-300) for a stay of proceedings in U.S. District Court, submitted to The Chief Justice.
9	Oct 24 1989		Response to application (A89-300) from respondent requested by The Chief Justice, due October 26, 1989.
10	Oct 24 1989		Response to application (A89-300) filed by respondent.
11	Oct 24 1989	*	Record filed.
12	Nov 1 1989		* Certified copy of original record and proceedings, 6 volumes, received. (Box).
13	Nov 1 1989		Application (A89-300) referred to the Court by the Chief Justice.
14	Nov 6 1989		(A89-300) NOVEMBER 3, 1989 CONFERENCE.
15	Nov 16 1989		Application (A89-300) denied by the Court.
16	Nov 16 1989		Brief amicus curiae of United States filed.
17	Nov 16 1989		Brief amici curiae of National Governors' Association, et al. filed.
18	Nov 16 1989		Brief amici curiae of Connecticut, et al. filed.
19	Nov 16 1989		Joint appendix filed.
21	Nov 24 1989	G	Brief of petitioners Gerald L. Baliles, etc., et al. filed.
			Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
20	Nov 27 1989		SET FOR ARGUMENT TUESDAY, JANUARY 9, 1990. (2ND CASE)
22	Dec 4 1989		Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
23	Dec 5 1989		CIRCULATED.
27	Dec 18 1989	X	Brief amici curiae of Gray Panthers Advocacy Committee, et al. filed.
24	Dec 20 1989	X	Brief amicus curiae of Temple University filed.

Entry	Date	Note	Proceedings and Orders
25	Dec 20 1989	X	Brief amici curiae of American Health Care Association, et al. filed.
26	Dec 20 1989	X	Brief of respondent Virginia Hospital Assn. filed.
28	Dec 20 1989	X	Brief amici curiae of California Assoc. of Hospitals and Health Systems, et al. filed.
29	Jan 2 1990	X	Reply brief of petitioners Gerald L. Baliles, etc., et al. filed.
30	Jan 9 1990		ARGUED.

NO. _____

FILED

JUN 15 1988

JOSEPH J. SANNIOL, JR.
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

GERALD L. BALILES, *et al.*,

Petitioners.

v.

THE VIRGINIA HOSPITAL ASSOCIATION,

Respondent.

PETITION FOR WRIT OF CERTIORARI TO THE
JUDGMENT OF THE UNITED STATES COURT
OF APPEALS FOR THE FOURTH CIRCUIT

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QUESTIONS PRESENTED

1. Whether a Medicaid provider has a private federal cause of action under 42 U.S.C. § 1983 to enforce the Medicaid Act against a state.
2. Whether the Eleventh Amendment can be negated by mechanical application of the rule of *Ex Parte Young* to permit relief against state officials, even if they have relied in good faith on specific judicial and administrative precedent.
3. Whether a facial challenge to a state Medicaid regulation under 42 U.S.C. § 1983 may be brought without the bar of any statute of limitations.
4. Whether a federal court should intervene in a state's comprehensive system for administrative and judicial review of Medicaid provider disputes, particularly where the plaintiffs have never attempted to use that system.

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IN THE

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OCTOBER TERM, 1988

GERALD L. BALILES, et al.,

Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,

Respondent.

**PETITION FOR WRIT OF CERTIORARI TO THE
JUDGMENT OF THE UNITED STATES COURT
OF APPEALS FOR THE FOURTH CIRCUIT**

The Commonwealth of Virginia ("the Commonwealth") whose officials were Appellants below, hereby petitions this Court for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fourth Circuit in this matter.¹

**I.
OPINIONS BELOW**

The opinion of the United States Court of Appeals for the Fourth Circuit, dated February 22, 1989, is reported at 868 F.2d 653 and is also

¹ Appellants in the Court of Appeals and defendants in the District Court are the Governor and the Secretary of Health and Human Resources of the Commonwealth, as well as the Director of the Department of Medical Assistance Services and members of the Virginia Board of Medical Assistance Services. Although the Governor and Secretary were initially sued in their individual capacities, they were dismissed in such capacities by consent of the plaintiff and by order of the district court on May 2, 1986. They are all now sued only in their official capacities. Plaintiff in the District Court and appellee in the Court of Appeals is the Virginia Hospital Association, a Virginia corporation. In the Court of Appeals, 27 states filed or joined an amicus brief in support of the Commonwealth on one issue. The American Hospital Association filed an amicus brief in support of the Virginia Hospital Association on that same issue.

set forth in Appendix A. The March 22, 1989 order of the Court of Appeals denying the Commonwealth's Petition for Rehearing and Suggestion for Rehearing *En Banc* is set forth in Appendix B. The March 29, 1989 order of the Court of Appeals denying a stay of its mandate is set forth in Appendix C.

The order and opinion of the United States District Court for the Eastern Division of Virginia, Richmond Division, dated May 18, 1988, are unreported and are set forth in Appendix D.

II. JURISDICTION

The jurisdiction of this Court to issue a writ of certiorari in this case is grounded upon 28 U.S.C. § 1254(1).

III. CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

This case involves the application of the Eleventh Amendment to the United States Constitution, which provides:

The judicial power of the United States shall not be construed to extend to any suit in law or equity, commenced or prosecuted against one of the United States by citizens of another state, or by citizens or subjects of any foreign state.

While this case also involves the construction and application of a number of provisions of Title XIX of the Social Security Act (42 U.S.C. § 1396, et seq.) ("the Medicaid Act"), the most important provision is 42 U.S.C. § 1396a(a)(13)(A), which reads, in pertinent part, as follows:

A state plan for medical assistance must . . . provide . . . for payment . . . of the hospital . . . services provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services . . . and to assure that individuals eligible for medical assistance have reasonable access . . .

IV. STATEMENT OF THE CASE

A. Procedural Background

On March 19, 1986, the Virginia Hospital Association ("VHA") filed this suit in the District Court challenging the validity of the regulatory methodology whereby the Commonwealth's Medicaid Program, which is administered by the Virginia Department of Medical Assistance Services ("DMAS") pursuant to Chapter 10, Title 32.1 (§ 32.1-323, *et seq.*) of the Code of Virginia, establishes reimbursement rates for participating hospitals. The suit challenges the validity of the mechanism ("Reimbursement System") whereby DMAS sets prospective *per diem* rates for inpatient hospital care of Medicaid patients, as well as the validity of the regulations prescribing procedures for the filing and processing of appeals ("Appeals System") by hospitals not satisfied with their prospective rates.

On September 22, 1986, the District Court dismissed the complaint. It ruled that VHA, being in privity with one of its member hospitals which had been a plaintiff in earlier litigation in the same court on the same subject, was collaterally estopped from bringing this action by reason of the earlier unfavorable ruling in *Mary Washington Hospital v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985).

On appeal, the Court of Appeals reversed. *Virginia Hospital Association v. Baliles*, 830 F. 2d 1308 (4th Cir. 1987).

Upon remand, the Commonwealth moved to dismiss on eight jurisdictional grounds. The District Court denied the motion, but on May 18, 1988, certified these eight issues to the Court of Appeals for interlocutory appeal. The Court of Appeals on July 27, 1988, granted that appeal. On February 22, 1989, it upheld the ruling of the District Court and on March 22, 1989, denied the Commonwealth's petition for rehearing and suggestion for rehearing *en banc*. On March 29, 1989, it denied a stay of its mandate pending the filing of this petition.

B. Factual Background

The Commonwealth, like all states, participates in the national Medicaid Program pursuant to the Medicaid Act. As noted above, DMAS is the agency of the Commonwealth which has been charged since 1985 with the responsibility for administering that program. Under

the program, DMAS has promulgated implementing regulations known collectively as the State Plan.

Until 1981, the Medicaid Act required states to pay participating hospitals the "reasonable cost" of inpatient services to Medicaid patients. In 1982, in response to the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), the Commonwealth, like many other states, adopted the Reimbursement System as an amendment to the State Plan to allow the use of prospective reimbursement for hospital services, effective July 1, 1982. Under the Reimbursement System, cost medians from 1981 data were used as a starting point and an inflator, the Consumer Price Index ("CPI"), was used to inflate such medians for subsequent years.

In 1983, one of VHA's member hospitals brought a challenge to the Reimbursement System. *Mary Washington Hospital, supra*. In that case, the District Court on January 4, 1985, upheld the legality of the Reimbursement System in its entirety, except for its distinct appeals mechanism. The District Court ordered the Commonwealth to promulgate a new appeals mechanism. That was done and the new Appeals System was adopted by DMAS in August 1985, and approved by the federal Health Care Financing Administration ("HCFA") on March 3, 1986. Subsequently, the District Court upheld the legality of the Appeals System by order dated April 21, 1986. No appeal from this order was taken.

With the exception of two replacements of the CPI with different inflators and other minor changes not relevant to this litigation, the Reimbursement System remains unchanged since its original promulgation in 1982. The Appeals System has not been amended at all since its 1985 promulgation. None of the over 100 member hospitals of VHA has pursued an appeal under the Appeals System, although they have preserved their right to do so.

V. JURISDICTION OF THE UNITED STATES DISTRICT COURT

The United States District Court for the Eastern District of Virginia, Richmond Division, assumed jurisdiction of this matter, in part pursuant to 42 U.S.C. § 1983. Whether it should have done so is one of the issues in this appeal.

VI.

REASONS WHY THE PETITION FOR CERTIORARI SHOULD BE GRANTED

INTRODUCTION

Rule 17.1 of the Rules of this Court provides that a writ of certiorari will be granted only when there are special and important reasons therefor. Rule 17.1(c) lists among such reasons a decision by a federal court of appeals on an important question of federal law which has not been, but should be, decided by this Court.

This case presents four such questions, any one of which meets the foregoing criterion. Recent federally-mandated growth of state Medicaid programs, rapid inflation of health care costs and the growing needs of an elderly indigent population have combined to create an unprecedented demand for Medicaid services. As state Medicaid budgets grow, litigation between providers and the states has increased.

In this context, the Court of Appeals has opened the federal courts to providers of health care to litigate reimbursement disputes against states under the Reconstruction era federal civil rights statutes. In so doing, it has placed the financial interests of providers on an equal footing with the civil rights of the sick and needy. It has further allowed a state to be stripped of its Eleventh Amendment immunity by the simple process of suing its officials -- even those whose good faith has not been and cannot be questioned. It has removed any statute of limitations bar from a facial challenge to Medicaid reimbursement regulations. Finally, although federal law gives the states the lead role in the national Medicaid Program, the Court of Appeals has allowed federal courts, essentially on demand, to hear disputes designed for state resolution.

Given this result, the interest of 27 states in joining the Commonwealth as amicus below is understandable. Final and timely resolution of the important national issues of both law and policy presented in this appeal will define the future scope and direction of Medicaid provider litigation. Equally important, it will determine whether the national Medicaid crisis will be exacerbated by the unnecessary federalization of legal disputes between the states and providers regarding financial reimbursement that can be ably and fairly adjudicated by state courts.

A.

By Treating Health Care Providers As The Intended Beneficiaries With Enforceable Rights, the Courts Below Have Restricted The Medicaid Program

This case presents an important question that will determine the future direction of Medicaid programs nationwide. This Court agreed to decide the same issue in 1987, but did not address the merits because of changes in the underlying facts that rendered the case under review moot.² The question presented is whether a health care provider, such as a hospital, has rights under the Medicaid Act that are enforceable privately against the states in federal court.

The Court of Appeals correctly noted (App. at A-5) that the Medicaid Act does not confer an express right of action on health care providers. Nonetheless, the Court came to the conclusion that Congress intended such providers, when seeking revised Medicaid rates, to have an implied right of action against the states, enforceable under 42 U.S.C. § 1983 ("§1983").

In *Wright v. Roanoke Redevelopment & Housing Authority*, 479 U.S. 418 (1987), and earlier in *Cort v. Ash*, 422 U.S. 66 (1975), this Court instructed federal courts how to determine whether a particular plaintiff is entitled to sue under § 1983 when, as here, the underlying federal statute on which the claim is based is silent. The primary focus of that inquiry is whether the plaintiff, here an association of hospitals, is part of the special class for whose benefit the statute was enacted.

In answering that question in the affirmative, the lower courts in this case found that hospitals are among the intended beneficiaries of the Medicaid Program, a national joint federal/state welfare program designed to pay medical expenses for the eligible poor. For a rationale, the decisions below (App. at A-7,8; D-4, 5) simply point to lengthy requirements in the Medicaid Act prescribing the content of state plans and conclude that Congress meant these requirements to be enforceable by providers directly against the states.³

² *Coos Bay Care Center v. Oregon Department of Human Resources*, 803 F. 2d 1060, (9th Cir. 1986), cert. granted, 107 S.Ct. 1970 (1987), judgment vacated and remanded on the issue of mootness, 108 S.Ct. 52 (1987).

³ Participation in the Medicaid Program is voluntary, except as to those providers who have contracted to participate for other reasons, such as the valuable consideration received under the Hill-Burton program. 42 U.S.C. § 291, *et seq.* Since providers are not compelled to participate in the Medicaid Program, there is no reason to imply enforceable rights for them other than those created by provider contracts. Such contracts, voluntarily renewed on a regular basis, obligate the provider to accept program payments.

Such conclusory analysis is not consistent with Congressional intent or this Court's decisions. The original legislative history of the Medicaid Act contains no evidence that Congress intended the Medicaid Program to benefit health care providers. S. Rep. No. 404, 89th Cong., 1st Sess., reprinted in 1965 U. S. Code Cong. & Admin. News 1943⁴. To the contrary, the legislative record shows conclusively that the growing and increasingly complex provisions of the Medicaid Act -- and in particular 42 U.S.C. § 1396a(a)(13)(A) reprinted in Part III, *supra* -- are designed to guide HCFA in its continuous oversight and review of state plans and programs. A correct reading of that section and the underlying regulations (42 C.F.R. § 447.250 *et seq.*) makes clear that the only obligation of participating states with respect to hospital reimbursement is to make findings and assurances to the Secretary (HCFA) and to obtain the approval of the latter as a pre-condition to federal funding. Both VHA and the lower courts rely upon only a portion of the statute; in so doing they reach an untenable result.

Over a decade ago, Congress mandated and, within a year thereafter, repealed a requirement that states waive their Eleventh Amendment immunity from suits by hospitals over reimbursement as a condition of participating in the federal Medicaid Program -- the precise subject of this litigation. At the same time, concerned that providers would not have a forum in which to raise such issues, Congress specifically directed HCFA to develop a mechanism for adjudication of disputes concerning Medicaid reimbursement rates. S. Rep. No. 1240, 94th Cong., 2nd Sess., reprinted in 1976 U.S. Code Cong. & Admin. News 5648, 5649-51. What resulted is the present federal regulation requiring state appeals procedures such as the Appeals System. See 42 C.F.R. § 447.253(c).

The decision of the Court of Appeals expressly discounts the role and degree of federal oversight in the Medicaid Program. (App. at A-10). Given the extensive system of plan approvals, audits and policy review currently in place, the better interpretation is that Congress -- consistent with this Court's decision in *Wright, supra*, -- has put in place a comprehensive framework of federal enforcement that *forecloses*, rather than implies, a private cause of action.

⁴ The self-explanatory stated purpose of the Medicaid Act is:

For the purpose of enabling each State as far as practicable under the conditions in such State to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care. . . .

42 U.S.C. § 1396.

Despite the weight of authority indicating that Congress intended states not to be subject to federal suits by providers under the Medicaid Act, the decisions below reached the opposite result. Providers are now free either to sue a state in federal court or to pursue an appeal under the state appeals procedures. This creates a dual system of review never intended by Congress and inconsistent with the states' orderly administration of their Medicaid programs. It threatens to flood the federal courts with suits that can and should be resolved in state administrative or judicial forums.⁵

Thus, the lower court decisions in this case have, by judicial fiat, turned the Medicaid Program, a welfare program for needy patients, into an entitlement program for health care providers and have thereby duplicated existing state administrative procedures mandated by Congress. This result is not consistent with the exercise of cooperative federalism through the operation of a Medicaid Program in which the states have the laboring oar. This Court must prevent the growth of unproductive federal litigation by providers and thereby avoid the threat of serious harm to this critical welfare program, the only source of medical assistance for many indigent and elderly citizens.

B.

Mechanical Application Of This Court's *Ex Parte Young* Decision Has Improperly Negated The States' Eleventh Amendment Immunity

This case also presents an issue central to the continued vitality of the federal system: the extent to which the Eleventh Amendment immunity of the states can be eroded by an unnecessarily broad reading of the doctrine first enunciated in *Ex Parte Young*, 209 U.S. 123 (1908).

The Eleventh Amendment bars suit in federal court against an unconsenting state brought by its own citizens, as well as citizens of another state. *Papasan v. Allain*, 478 U.S. 265, 276 (1986); *Atascadero State Hospital v. Scanlon*, 473 U.S. 234, 238 (1985); *Pennhurst State School & Hospital v. Halderman*, 465 U.S. 89, 109 (1984). Unless the Commonwealth has waived its immunity by expressly consenting to this

⁵ As indicated in note 1, *supra*, 27 states supported the Commonwealth through an amicus brief in the Court of Appeals. Their principal concern was that a result such as that reached by the Court of Appeals will render superfluous the provider appeals systems developed by each state, will hamper the orderly administration of the various Medicaid programs and will intrude into the states' ability to implement their approved programs. The Court of Appeals paid lip service to this concern (App. at A-10, n.7), but rejected it.

suit (which it has not) or this case involves substantive rights secured either by the Fourteenth Amendment or by a federal statute expressly enacted to implement the Fourteenth Amendment (which it does not), the district court lacks jurisdiction over this action.⁶

VHA has sued the named defendants, officials of the Commonwealth, in their official capacities only. See note 1, *supra*. As a result, this action is, by consent of the parties, one that seeks relief against the Commonwealth itself, not against any officials individually. The Court of Appeals (App. at A-13) recognized that the Commonwealth is the real party at interest. Since a state, which is not a natural person, can only be required to act through its officials, there is no doubt that the relief sought by VHA -- revision of Medicaid hospital reimbursement rates --would operate only against the Commonwealth, not against the individual officials.

This Court has accepted the proposition that "[t]he Eleventh Amendment bars a suit against state officials when 'the state is the real, substantial party in interest.' " *Pennhurst, supra*, 465 U.S. at 101. Nonetheless, the ruling in this case is that, by seeking only prospective and injunctive relief, VHA has alleged a sufficient basis to bring the case under the exception to Eleventh Amendment immunity first announced by this Court in *Ex Parte Young*.

Application of *Ex Parte Young* has caused this Court increasing difficulty in recent years. *Pennhurst, supra*, 465 U.S. at 114 n.25; *Florida Dept. of State v. Treasure Salvors, Inc.*, 458 U.S. 670 (1982). The salient facts of *Young* are simple. Young, a state attorney general, continued deliberate enforcement of an allegedly unconstitutional statute in violation of a federal injunction. This Court, declining to award damages against the state, created what it now accepts to be an increasingly narrowly-construed "fiction". The "fiction" assumed that because a state would not authorize behavior such as that of Young, his actions were therefore *ultra vires* and stripped of their official character. *Pennhurst, supra*, 456 U.S. at 114 n.25. Thus, although he was acting "under color of state law" as the state's attorney general, Young was held to be acting

⁶ The Medicaid Act, the sole statutory basis for this suit, is a spending power statute, as the Court of Appeals correctly assumed. App. at A-6, n.3. Congress did not evidence an "unmistakable purpose" under § 5 of the Fourteenth Amendment to abrogate the states' Eleventh Amendment immunity as a condition to receiving federal funds. *Atascadero, supra*, 473 U.S. at 247. In fact, as noted in Part A, *supra*, Congress once required a waiver of Eleventh Amendment immunity by the states in order to participate in the Medicaid Program, but specifically repealed that requirement in 1976. *Florida Dept. of Health and Rehabilitative Services v. Florida Nursing Home Assn.*, 450 U.S. 147, 150 n.3 (1981).

as an individual and not as the state, so a federal injunction would lie against him.

When applied to this case, it is clear that *Ex Parte Young* has been stretched well beyond its original facts. Its misuse in this case is evident. The practical effect of the application of the "fiction" here is to eliminate the Eleventh Amendment defense and thereby to deprive the states of their constitutional protection against federal suits.

The lower courts in this case and others have failed to analyze and apply *Ex Parte Young* correctly. The original ruling rests on two main points: (1) the conduct of Young and (2) the application of the "fiction" to allow the granting of prospective injunctive relief against a state official. But, over the years and culminating with the present case, federal courts often have looked only at the second point, the nature of the relief sought. This truncated analysis has progressed to the point where, as here, all that is necessary to defeat Eleventh Amendment immunity is for a plaintiff to allege a violation of federal law and to seek prospective relief. (App. at A-13, 14).⁷

If that is really the appropriate test, the Eleventh Amendment is rendered a mere shadow and the fictional exception developed for a "bad actor" like Young has swallowed the rule. Here, contemporaneously with the filing of this suit, the same District Court upheld the same Reimbursement System and the identical Appeals System in *Mary Washington Hospital, supra*. Both were approved by HCFA. Despite this background, officials of the Commonwealth – named in their official capacities – who justifiably relied upon those federal judicial and administrative approvals, have been treated by the lower courts indistinguishably from Young, a state official who defied the federal courts.

To consider the two situations analogous is neither logical nor sound policy. This Court should re-consider *Ex Parte Young* or, at the very least, should require the lower courts to engage in an examination of the facts sufficient to apply the full two-part analysis of that case. If that were done, it is clear that the officials of the Commonwealth sued in this case would not be shorn of their official status, and as an official-capacity suit against the Commonwealth, the suit would not be allowed to proceed in federal court. Absent application of the *Ex Parte Young* "fiction," relief that is inconsistent with the Eleventh Amendment's plain bar

⁷ This Court has refused to allow plaintiffs to tailor the relief sought so as to permit an "end run" around the Eleventh Amendment. *Green v. Mansour*, 474 U.S. 64, 73 (1985). As here, VHA's suit to force revision of the Reimbursement System, while couched as a suit for prospective relief, is in reality designed to produce financial relief payable from the treasury of the Commonwealth.

against both legal and equitable remedies cannot be granted against a state.⁸

C.

The Lower Court Improperly Disregarded The Statute Of Limitations In Facial Challenges To Medicaid Regulations

The Court of Appeals ruled that a plaintiff may bring suit at any time under 42 U.S.C. § 1983 to challenge on its face a judicially and federally approved state Medicaid regulation. Under the Court of Appeals' analysis, such suit will be subject to no statute of limitations if the plaintiff merely alleges that the regulation is unconstitutional.

This stretches the "continuing violation" theory enunciated in *Brown v. Board of Education*, 347 U.S. 483 (1954) and its progeny far beyond its intended meaning.

In accordance with *Wilson v. Garcia*, 471 U.S. 261 (1985), the Court of Appeals (App. at A-15) recognized that, under 42 U.S.C. § 1983, the pertinent limitations period, borrowed from § 8.01-243(A) of the Code of Virginia, is two years. It also recognized that this case was brought in March 1986, almost four years after the promulgation of the Reimbursement System on July 1, 1982. In ruling that this action is not time-barred, the Court of Appeals ignored the critical fact that the challenged Reimbursement System had previously been upheld by the District Court.

That decision in *Mary Washington Hospital, supra*, renders illogical the Court of Appeals' conclusion that the statute of limitations has never run. The Court's analysis looks only to one aspect of the concept of a "continuing violation." The appropriate inquiry logically should involve a two-part analysis: first, whether the complained of conduct is continuing in nature; second, whether the allegation of a violation has any merit. Because the District Court contemporaneously with the filing of this suit had already held the challenged regulations to be facially valid (see, *Mary Washington, supra*), there is no basis in law, fact or policy to

⁸ Alternatively, if this Court does sanction the routine application of the fiction that a state official may be deprived of his official status and the state of its Eleventh Amendment immunity merely through a plaintiff's pleading of federal law and request for prospective relief, these officials must of necessity be treated as sued in their individual capacities, despite the specific agreement of VHA in this case not to do so. In that event, sound policy dictates that these officials be allowed to rely upon good faith immunity as a defense, not just against damages, but from suit as well. *Mitchell v. Forsyth*, 472 U.S. 511, 526 (1985).

conclude that VHA's allegation of a violation is anything more than that -- a mere allegation. In light of these facts, application of a "continuing violation" rationale to this case is unsound. This Court should not permit a mere allegation to subject a state to relitigation of judicially approved regulations.⁹

In addition, the Court of Appeals, citing *Brown, supra*, *Eldridge v. Bouchard*, 645 F.Supp. 749 (W.D. Va. 1986), *aff'd* 823 F.2d 546 (4th Cir. 1987) and *Long v. Florida*, 805 F.2d 1542 (11th Cir. 1986), concluded that the "continuing violation" theory derived from these "as applied" cases should control even though the plaintiff is not a hospital to whom the challenged regulations apply. VHA, a trade association, can bring this action only as a facial challenge. It cannot allege an "as applied" violation because it is merely a surrogate for its members.¹⁰ Nevertheless, the Court's analysis of *Brown*, *Eldridge* and *Long*, all cases premised upon continuing violations of civil rights' laws "as applied" to specific plaintiffs, is now the rule in the Fourth Circuit for *facial* challenges to regulations.

The practical application of this decision will lead to inconsistent and illogical results. Associational plaintiffs bringing facial challenges in federal court to state regulations will not be subject to or barred by any statute of limitations. Medicaid recipients who fail to challenge a denial or termination of their eligibility, however, will continue to be time-barred after two years, even though their ineligibility continues. Individual providers who fail to challenge a reimbursement action, even though its effect will carry forward, presumably also will continue to be time-barred. Compare, *Randall v. Lukhard*, 709 F.2d 257, 262 n.7 (4th Cir. 1983). The result is that as long as a regulation is in effect, a non-provider surrogate may now bring a facial challenge to the regulation. Such a cause of action presumably will extend indefinitely back to the date of promulgation -- in this case almost four years. This result gives associational plaintiffs greater rights than their members possess and

counteracts the concept of finality that is the mainstay of, and purpose behind, any statute of limitations.¹¹

The decision below subjects the states to the threat of a perpetual challenge to regulations essential to the operation of their Medicaid programs. This Court can readily appreciate the potential disruption to these programs and in other areas of the law. In the interest of sound public policy, long-standing national principles of repose should not be circumvented or discarded piecemeal.

D.

Intervention By Federal Courts Into A Comprehensive State Regulatory System Violates Fundamental Principles Of Comity, Particularly When The Plaintiffs Have Not Attempted To Use That System

As a matter of comity and in the interest of orderly administration of the federal judicial system, the Court should direct federal courts not to intervene in disputes for which an adequate state remedy exists. This is particularly so where, as here, the plaintiffs have chosen to ignore a state remedy fashioned in compliance with federal law and approved both by a federal court and a federal agency.

Under this Court's decision in *Burford v. Sun Oil Co.*, 319 U.S. 315 (1943), as further refined in *Colorado River Water Conservation District v. United States*, 424 U.S. 800 (1976), federal courts should abstain from assuming jurisdiction over a matter that is of substantial state concern. The courts especially should do so if a state has established a comprehensive regulatory framework and specialized review, if such intervention would create disruption of the state system, and if the state system can adequately vindicate any federal rights at issue.

In declining to apply the *Burford* rule, the courts below ignored the state laws and procedures constituting the Commonwealth's Medicaid Program. The Commonwealth has established an extensive system of review for the resolution of provider disputes. Title 32.1, Chapter 10 of the Code of Virginia requires DMAS and its Board to administer and

⁹ The doctrine of *stare decisis* ought to prevent such a result, absent any changes in the facts. The lower courts, however, postponed any consideration of the application of this rule. App. at A-13, D-6. Thus, they never looked beyond the bare allegation of unconstitutionality made by VHA.

¹⁰ See, *Virginia Hospital Association v. Baliles, supra*, 830 F.2d at 1312-1313, where the Court of Appeals found that VHA is not a health care provider and cannot be directly affected by the outcome of this litigation. Its finding is the rule of this case.

¹¹ Even under a true "continuing violation" theory which creates a new cause of action for every *application* of the challenged regulations, thereby renewing the applicable period of limitations, the lower courts should not have allowed this challenge to extend back in time more than two years from the 1986 filing date. If the ruling of the Court of Appeals stands, however, VHA, again as an association, may well have obtained greater rights than any of its members have individually.

regulate the payment of Medicaid funds in Virginia.¹² Section 32.1-325.1 of the Code of Virginia directs that provider appeals be administered in accordance with the State Plan and with the Virginia Administrative Process Act, § 9-6.14:1, *et seq.* of the Code of Virginia.

Acting under its statutory authority, the Board of DMAS has established the State Plan, a comprehensive regulation of several hundred pages, a significant portion of which deals expressly with provider reimbursement. The Reimbursement System defines how payments are determined for hospitals and the Appeals System provides a detailed procedure for resolution of payment disputes. Under the Appeals System, three distinct levels (informal conference, formal hearing and agency head decision) of review by administrators experienced in Medicaid reimbursement are available to every provider.

Thereafter, two levels of judicial review -- to the Virginia circuit courts and to the Virginia Court of Appeals -- are available as of right. A third, to the Supreme Court of Virginia, is available by writ. Subject to issuance of a such a writ, the Virginia Court of Appeals is vested with final appellate jurisdiction *inter alia* over decisions originating before agencies of the Commonwealth pursuant to § 17-116.07(A)(2) of the Code of Virginia. As a result, that court has developed considerable expertise in administrative law. Through its concentration in this area, it increasingly specializes in the review of administrative decisions.

The Virginia Administrative Process Act, and § 9-6.14:17 of the Code of Virginia in particular, assures that the broadest range of factual and legal issues are heard by the courts of the Commonwealth.¹³ The District Court had no basis, because none exists, to suggest that Virginia courts do not provide a full and fair opportunity for resolution of disputes such as that brought by VHA. Absent a factual basis for concluding a fair hearing is unavailable in state proceedings, federal abstention is appropriate. *Ohio Civil Rights Commission v. Dayton Christian Schools*, 477 U.S. 619, 627 (1986).

Nonetheless, the courts below have ignored the Commonwealth's comprehensive review process and intervened in a state matter solely at the request of VHA. Such intervention is inconsistent with the proper operation of a federal system. Federal law mandates a state-administered system for resolution of provider disputes. The Commonwealth has a

¹² All states participating as amici in the Court of Appeals have similar but not identical systems.

¹³ See, e.g., *Bridgewater Home, Inc. v. Commonwealth of Virginia* (Va. App. Record No. 0888-87-4, July 22, 1988), a Medicaid provider dispute raising both state and federal issues.

system approved by HCFA and the District Court. Rather than allowing that system to work as intended, the Court of Appeals has sanctioned repeated federal judicial intervention into the process. Such intervention will effectively supplant the systems established by the states.¹⁴

It is doubly inappropriate for federal courts to intervene in the Commonwealth's Medicaid Program when, as the Court of Appeals acknowledged, none of VHA's members has attempted to prosecute any appeals filed under the Appeals System. Despite this finding, the Court of Appeals allowed VHA, on behalf of its members, to proceed with a challenge to the untested Appeals System. App. at A-16.¹⁵

Because no VHA member has pursued any of the appeals on file, all the lower courts had before them were assertions of aggregate hardship by a surrogate trade association. The Court of Appeals nevertheless found these allegations by VHA sufficient to meet the two requirements for ripeness -- appropriateness for judicial resolution and hardship -- announced by this Court in *Toilet Goods Association, Inc. v. Gardner*, 387 U.S. 158, 162 (1967). This Court should require the lower courts to decline to entertain speculative actions in which no state record has been developed, particularly in the context of a state Medicaid program. See, e.g., *Wilmac Corporation v. Bowen*, 811 F.2d 809 (3rd Cir. 1987).

This Court should direct the lower courts to abstain from entertaining this action in the absence of any compelling reason to do so and in the absence of a justiciable dispute. If it does not, similar appeals are likely to burden the federal court system and disrupt the states' administration of their various Medicaid programs.

VII. CONCLUSION

The lower courts have improperly restructured the national Medicaid Program and have eliminated Eleventh Amendment immunity, as well as the application of any statute of limitations, in an action such as

¹⁴ The Medicaid Act and federal regulations require uniform statewide application of the State Plan. See, e.g., 42 C.F.R. § 431.50. Moreover, it is axiomatic that administration of the Virginia Medicaid Program, which exceeds eight percent of the Commonwealth's total biennial budget, is a matter of substantial concern to the Commonwealth.

¹⁵ In successfully asserting its standing to bring this suit, VHA convinced the courts below it does not need to use data specific to its individual member hospitals. (App. at A-14, 15; D-4). Accordingly, the outcome of this facial challenge cannot resolve the specific reimbursement disputes of any of those hospitals. Because none has pursued an appeal, none actually knows whether it can obtain increased reimbursement under present procedures. Success in this litigation will not change that result.

this. Federal court intervention threatens principles of comity and the orderly administration of state Medicaid programs. For these reasons, the Court of Appeals' ruling should be reversed.

WHEREFORE, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

NO. 88-1306

THE VIRGINIA HOSPITAL ASSOCIATION

Plaintiff-Appellee

versus

GERALD BALILES, Governor of Virginia;
EVA S. TEIG, Secretary of Human Resources of
Commonwealth of Virginia; BRUCE U.
KOZLOWSKI, Director, Medical Assistance
Services; BETTE O. KANTER, Member State
Board of Medical Assistance Services; JOSEPH M.
TEEFY, Member State Board of Medical
Assistance Services; R. MICHAEL BERRYMAN,
Member State Board of Medical Assistance
Services; FORD TUCKER JOHNSON, SR., D. D.
S. Member State Board of Medical Assistance
Services; A. EPPS, JR., Medical Doctor RUTH
HANFT, Member State Board of Medical
Assistance Services; BERTHA L. DAVIS, Ph.D.,
Member State Board of Medical Assistance
Services; KATHLEEN LEUTZE, Member State
Board of Medical Assistance Services; ROBERT N.
LAMBETH, JR., Member State Board of Medical
Assistance Services; ELSA A. PORTER, Member
State Board of Medical Assistance Services; JOHN
N. SIMPSON, Member State Board of Medical
Assistance Services;

Defendants-Appellants

State of Alaska; State of Arizona; State of
California; State of Florida; State of Georgia; State
of Idaho; State of Indiana; State of Kansas; State of
Michigan; State of Minnesota; State of Missouri;
State of New Hampshire; State of New Jersey;

State of New Mexico; State of North Dakota;
Commonwealth of Pennsylvania; State of Rhode
Island; State of South Carolina; State of South
Dakota; State of Tennessee; State of Vermont;
State of Wisconsin; State of Wyoming; American
Hospital Association

Amicus Curiae

Appeal from the United States District Court for the Eastern District of Virginia, at Richmond. Robert R. Merhige, Jr., Senior District Judge. (CA 86-166-R)

Argued: October 31, 1988

Decided: February 22, 1989

Before RUSSELL and ERVIN, Circuit Judges, and KISER, United States District Judge for the Western District of Virginia, sitting by designation.

Roger Lewis Chaffe, Senior Assistant Attorney General (Mary Sue Terry, Attorney General; R. Claire Guthrie, Deputy Attorney General; Pamela M. Reed, Virginia R. Manhard, Assistant Attorneys General, on brief) for Appellants. Martin Andrew Donlan, Jr. (Judith B. Henry, Peter M. Mellette, Lynne Fleming, CREWS & HANCOCK on brief) for Appellee. (Gregory M. Luce, Irwin Cohen, Martha Ellett, Eric Schwartz, FULBRIGHT & JAWORSKI; Michael F. Anthony, AMERICAN HOSPITAL ASSOCIATION on brief) for Amicus Curiae American Hospital Association. (Dave Frahnmayer, Attorney General of Oregon, William F. Gary, Deputy Attorney General, Virginia L. Linder, Solicitor General, Kendall M. Barnes, Jr., Assistant Attorney General; Grace Berg Schaible, Attorney General of Alaska; Robert K. Corbin, Attorney General of Arizona; John K. Vandekamp, Attorney General of California; Robert A. Butterworth, Attorney General of Florida; Michael J. Bower, Attorney General of Georgia; James T. Jones, Attorney General of Idaho; Linley E. Pearson, Attorney General of Indiana; Robert T. Stephan, Attorney General of Kansas; Frank J. Kelley, Attorney General of Michigan; Hubert H. Humphrey, III, Attorney General of Minnesota; William L. Webster, Attorney General, State of Missouri; Brian McKay, Attorney General of Nevada; Stephen E. Merrill, Attorney General of New Hampshire; Cary Edwards, Attorney General of New Jersey; Hal

Stratton, Attorney General of New Mexico; Nicholas Spaeth, Attorney General of North Dakota; Leroy S. Zimmerman, Attorney General, John G. Knorr, III, Chief Deputy Attorney General, Commonwealth of Pennsylvania; James E. O'Neil, Attorney General of Rhode Island; T. Travis Medlock, Attorney General of South Carolina; Roger A. Tellinghuisen, Attorney General of South Dakota; W. J. Michael Cody, Attorney General of Tennessee; Jeffrey L. Amestoy, Attorney General of Vermont; Donald J. Hanaway, Attorney General of Wisconsin; Joseph B. Meyer, Attorney General of Wyoming, on brief) for state Amici Curiae.

ERVIN, Circuit Judge:

Defendants, officials of the government of the Commonwealth of Virginia,¹ (hereinafter collectively referred to as "Virginia") appeal the denial of their motion for summary judgment seeking to dismiss an action commenced against them by the Virginia Hospital Association ("VHA"). VHA is a nonprofit organization, the members of which are all public or private Virginia health care providers, principally hospitals ("providers"). VHA sued to enjoin the procedures Virginia uses to determine what rate of reimbursement VHA members receive for treating Medicaid patients. Virginia argued that for various reasons VHA's suit is not currently justiciable. The district court disagreed and certified its order for appeal under 28 U.S.C.A. § 1292(b). We affirm.

I

VHA brought this § 1983 action to challenge Virginia's procedures for reimbursing hospitals for the costs of treating Medicaid patients ("Virginia Plan").² VHA seeks the following relief: (1) a declaration that the Virginia Plan violates the Medicaid Act, 42 U.S.C.A. § 1396_et seq. ("Medicaid Act"), and therefore also the Supremacy Clause ("Count I"); (2) a declaration that the Virginia Plan violates its members' due process rights ("Count II"); (3) a permanent injunction of the Virginia Plan ("Count III").

On September 22, 1986, the district court granted summary judgment for Virginia on the ground that collateral estoppel precluded VHA from litigating issues decided in *Mary Washington Hospital, Inc. v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985), a similar action brought by one VHA

¹ Defendants are the Governor of the Commonwealth of Virginia, Gerald L. Baliles, as well as the Commonwealth's Secretary of Human Resources and Director of Medical Assistance Services, and members of the Commonwealth's Board of Medical Assistance Services ("DMAS").

² The Omnibus Budget Reconciliation Act of 1981 ("OBRA") included the Boren Amendment, codified at 42 U.S.C.A. 1396a(a)(13)(A) (West Supp. 1988). The Boren Amendment requires Virginia, as a participant in the Medicaid program, to "provide . . . for payment . . . of the [medical] services provided under the [Virginia Plan] through the use of rates . . . which [Virginia] finds, and makes assurances satisfactory to the Secretary [of Health and Human Services], are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable . . . laws. . ." Section 1396a(a)(13)(A) amended § 1396a(a)(13)(E), under which Virginia had been required to determine reimbursement rates "on a reasonable cost-related basis. . ." In 1982, Virginia amended its Medicaid Plan to incorporate a prospective reimbursement rate-setting mechanism.

member hospital. We reversed that decision and remanded the case. *Virginia Hospital Association v. Baliles*, 830 F.2d 1308 (4th Cir. 1987).

Virginia then moved for summary judgment based on a number of nonjusticiability arguments. Virginia disputed VHA's contention that the Medicaid Act creates a right actionable under § 1983, and argued that the Medicaid Act evidences a congressional intent to foreclose private enforcement. Virginia further contended that *stare decisis* or the Eleventh Amendment barred VHA's suit, and that VHA lacked standing. Virginia alleged finally that the statute of limitations barred VHA's claim, that the claim is not ripe, and that the district court should abstain.

The district court denied Virginia's motion, holding the action currently justiciable. We agree and affirm.

II.

We believe Virginia's most substantial argument is that VHA has no right actionable under § 1983, and so we address that issue first.

A.

Virginia argues that only health care recipients, and not individual or associated health care providers, have rights enforceable under the Medicaid Act. We agree with the district court that the Medicaid Act supplies VHA with an enforceable right, and that Virginia failed to establish a congressional intent to foreclose private enforcement.

Section 1983 supplies VHA with no substantive rights. The statute serves simply as a vehicle to redress the deprivation under color of state law "of any rights . . . secured by the [federal] Constitution and laws. . ." 42 U.S.C.A. § 1983 (West 1981). The initial query is accordingly whether the Medicaid Act provides VHA with any substantive right.

There is no dispute that the Medicaid Act does not expressly confer a right of action on health care providers. The Supreme Court has held, however, that federal statutes may imply rights actionable under § 1983. *Maine v. Thiboutot*, 448 U.S. 1 (1980). A number of cases decided since *Thiboutot* have elaborated criteria for determining whether a particular statute implies a private right of action. In *Pennhurst State School v. Halderman*, 451 U.S. 1, 15 (1981), the Court made plain that the touchstone of the determination is congressional intent, as manifest in the language and legislative history of the statute. See also *Middlesex City Sewerage Auth. v. National Sea Clammers Ass'n*, 453 U.S. 1, 13 (1981).

In *Pennhurst*, the Court examined the text and legislative history of the Developmentally Disabled Assistance and Bill of Rights Act of 1975

("Assistance Act"), 42 U.S.C.A. § 6000 *et seq.*, a statute similar in some respects to the Medicaid Act. Both statutes create programs whereby the Federal Government provides money to States to fund programs for persons specially in need. State participation is voluntary under both statutes, but both require participating states to meet certain conditions to receive federal funds.³

The Court in *Pennhurst* noted that while many provisions of the Assistance Act expressly conditioned federal assistance on state compliance, the provision at issue, 42 U.S.C.A. § 6010, did not. 451 U.S. at 13. The Court also noted that the right the mentally retarded respondents claimed, that of "appropriate treatment" in the "least restrictive environment", would impose a massive financial obligation on participating states. 451 U.S. at 16-17. After examining the language and legislative history of § 6010 and other sections of the Assistance Act, the Court concluded that § 6010 was merely precatory and did not create a right in favor of the respondents. *Id.* at 18. See *Wright v. Roanoke Redevel & Hous. Auth.*, 479 U.S. 418, 423 (1987) ("In *Pennhurst*, a § 1983 action did not lie because the statutory provisions were thought to be only statements of "findings" indicating no more than a congressional preference — at most a "nudge in the preferred directio[n].") 451 U.S. at 19, and not intended to rise to the level of an enforceable right.").

We note at the outset of our analysis that two other circuits appear to have concluded that § 1396a(a)(13)(A) supplies providers with enforceable rights. *Colorado Health Care Ass'n v. Colorado Dep't of Social Serv.*, 842 F.2d 1158, 1164 n.5 (10th Cir. 1988); *Coos Bay Care Ctr. v. Oregon*, 803 F.2d 1060 (9th Cir. 1986), cert. granted, 107 S. Ct. 2970, vacated as moot, 108 S. Ct. 52 (1987). Because VHA is, for purposes of this decision, simply a medium through which its members have elected to litigate, these decisions respecting individual providers pertain to our consideration of VHA's derivative rights. We are also aware that another district court in this circuit appears to have reached the opposite conclusion in a case

³ The parties to this case have not briefed or argued under what constitutional provision Congress enacted the Medicaid Act. In *Pennhurst*, the Court found little support for the position that Congress had enacted the Assistance Act pursuant to its power under § 5 of the Fourteenth Amendment. 451 U.S. at 18. The Court instead concluded that Congress had acted pursuant to its spending power under Art. I, § 8, Cl. 1. For statutes enacted under the spending power, the Court held that "if Congress intend[ed] to impose a condition on the grant of federal monies, it must [have done] so unambiguously" and subject to certain limits not relevant to the decision. *Id.* at 17 and n.13. We assume that the Medicaid Act reflects the exercise only of Congress' spending power, and therefore conclude that the holdings in *Pennhurst* are among those that control in this case.

pending before us. *Vantage Healthcare Corp. v. Department of Medical Assistance Services*, 684 F. Supp. 1329 (E.D. Va. 1988) (appeal pending as No. 88-3872). The substantive issue in *Vantage* is not, as here, the propriety of reimbursement rates generally, but whether providers are entitled to a certain type of reimbursement, called a return on equity capital. This distinction means our decision in this case does not foreordain the outcome of *Vantage* and, as a corollary, that the district court's dismissal of *Vantage*'s § 1983 action does not necessarily bear on our resolution of this appeal.

We believe the language and legislative history of § 1396a(a)(13)(A) imply a congressional intent to allow providers a right of action against State failure to comply with federal Medicaid requirements. Virginia proposes, though, that the significant language of § 1396a(a)(13)(A) is the clause requiring Virginia to assure the Secretary of its compliance. In Virginia's view, as we understand it, it is the elaborate statement of the section's public welfare goals, [stipulating the conditions with which Virginia must comply] that is precatory. Once the Secretary has accepted Virginia's assurances that the plan will comply, there is no federal judicial authority to consider whether Virginia has made good on its promise. We believe a reading of § 1396a(a)(13)(A) in the context of the Medicaid Act, as *Pennhurst* requires, alone refutes Virginia's interpretation. The comments of the Congress that enacted the Boren Amendment dispel the argument even more forcefully.

It is true that § 1396a(a)(13)(A) does not in so many words condition federal assistance on state compliance with its express purpose, which is to require reimbursement rates that are "reasonable and adequate to meet the costs . . . incurred by efficiently and economically operated [providers] . . . and to assure that [Medicaid patients] have reasonable access . . . to inpatient hospital services of adequate quality. . . ." Virginia proposes that the intent behind § 1396a(a)(13)(A) is not forcefully to effect this purpose, but, as with the provision at issue in *Pennhurst*, simply to "nudge" the states toward action Congress did not see fit to make mandatory. We cannot agree with the proposition and conclude that § 1396a(a)(13)(A) reveals an unambiguous intent to assure reimbursement rates that are reasonable and adequate in fact.

Even a cursory reading of the forty-nine provisions of 42 U.S.C.A. § 1396a(a), which stipulate what a state Medicaid plan must include and provide, reveals that none is expressly conditional. Each provision is rather subject to the imperative of their predicate § 1396a(a), which indicates that the provisions specify what a State plan "must" contain. We believe the district court correctly concluded that § 1396a(a)(13)(A) reveals a

congressional intent to condition federal assistance on states' achievement of the express purpose of the section, and not simply on states' assurances of compliance.⁴

B.

The legislative history of § 1396a(a)(13)(A) strongly reinforces our interpretation. The Joint Explanatory Statement of the Committee of Conference, commenting on the bill as enacted, states flatly that "the conferees intend that state hospital reimbursement policies should meet the costs that must be incurred by efficiently administered hospitals in providing covered care and services to medicaid eligibles. . ." H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess. reprinted in 1981 U.S. Code Cong. & Admin. News 1324. The Conference Committee's bill contained much of the text of the bill proposed by the Senate Finance Committee, which had included "a provision requiring states to reimburse hospitals at rates (determined in accordance with methods and standards developed by the states) that are reasonable and adequate to meet the cost [sic] which must be incurred by efficient . . . and economical . . . [providers]." S. Rep. No. 139, 97th Cong., 2d Sess., reprinted in 1981 U.S. Code Cong. & Admin. News 697. The Committee's comments make plain that the latitude § 1396a(a)(13)(A) grants States is not willfully to assign reimbursement rates, but flexibly to determine what methods and factors will produce rates adequate in fact given the circumstances particular to each State's hospitals.⁵

⁴ The regulations implementing § 1396a(a)(13)(A) reinforce our interpretation that the section's requirement of adequate state assurances evinces no congressional intent to insulate State Medicaid reimbursement systems from federal judicial scrutiny. 42 C.F.R. §§ 447.250-280 (1987). The regulations suggest that the Secretary's task is not to consider the reasonableness of reimbursement rates at large, but rather to consider the adequacy of state assurances that "the methods and standards used by the [State] to set payment rates [are] consistent with 45 C.F.R. 201.2." 42 C.F.R. § 447.252(b); see also 42 U.C.C.A. § 1396a(a)(13)(A) (stating parenthetically that the states are responsible for developing methods and standards for determining reimbursement rates), 42 C.F.R. § 447.253(a)-(b). Moreover, the Secretary need not examine state assurances at all; 42 C.F.R. § 447.256(b) states that a state's assurances will be deemed accepted by the Secretary if the Secretary fails to notify the State of its determination within 90 days of receipt of the assurances.

⁵ Cf. S. Rep. No. 139, 97th Cong., 2d Sess., reprinted in 1981 U.S. Code Cong. & Admin. News 744 (Summary of Finance Committee Recommendations) ("The bill provides States with additional flexibility in determining the payment rate for inpatient hospital services. . . [The bill] substitutes a provision requiring states to reimburse hospitals at rates (Continued on next page.)

The legislative history also indicates that Congress intended no close scrutiny by the Secretary of Virginia's assurances of compliance with the mandates of § 1396a(a)(13)(A). 1984 U.S. Code Cong. & Admin. News 744. ("The [Senate Finance] committee expects that the Secretary will keep regulatory and other requirements to the minimum necessary to assure proper accountability, and not to overburden the states and [providers] with unnecessary and burdensome paperwork requirements. It is expected that the assurance made by the states will be considered satisfactory in the absence of a formal finding to the contrary by the Secretary.") See supra p. 9 n.3. This history indicates further the unreason of Virginia's proposition that Congress intended state review and assurances to be the sole means of assuring that the Virginia system provides reasonable access to care of adequate quality.

We are aware that OBRA purposed to reduce the federal budget, that § 1396a(a)(13)(A) aims to promote this purpose by implementing a more cost-efficient Medicaid scheme, and that a logical reading of § 1396a(a)(13)(A) could accordingly be that it insulates State reimbursement programs from challenges by hospitals compensated at new, lower rates. Our reading of § 1396a(a)(13)(A), however, is that it guarantees reasonable and adequate reimbursement to hospitals that achieve cost-efficiency. We believe that only this reading protects the balance for which Congress has striven between insuring health care to the poorest citizens and imposing a manageable burden on the federal and state treasuries.

Our view of § 1396a(a)(13)(A) allays the concern understandably influential in *Pennhurst*, that implying a private right of action may lead to crushing financial burdens that participating states could not have foreseen when they elected to participate in the Medicaid

⁶ (Continued from previous page.) (determined in accordance with methods and standards developed by the States) that are reasonable and adequate to meet the cost [sic] which must be incurred by efficiently and economically operated [providers]. . . The Committee continues to believe that States should have flexibility in developing methods of payment for their medicaid programs . . . The flexibility given the States is not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care.") The comments make plain that while States have considerable freedom to structure their reimbursement programs to encourage and maintain efficiency, the programs must produce rates related to providers' reasonable costs. These goals are not inconsistent. For example, the Committee comment indicates that a State could categorize providers in any number of ways. *Id.* As long as the categorization allowed for the promulgation of reasonable reimbursement rates, providers' complaints that another system would produce preferable rates would be unavailing.

program.⁶ 451 U.S. at 24-25. Virginia has not argued that the obligation VHA seeks to enforce against it, that it provide reasonable and adequate reimbursement rates, does not exist, or that Virginia could not reasonably have foreseen that we could interpret § 1396a(a)(13)(A) as we do today. Virginia argues only that a § 1983 action was not a permissible route by which VHA could present the merits of its grievance. We do not take any position on the merits of that grievance, but agree with the district court's threshold determination that VHA has a right enforceable under § 1983.

C.

Having concluded that § 1396a(a)(13)(A) confers a right on providers, we must now consider whether the Medicaid Act's enforcement provisions reveal an intent to foreclose a private judicial remedy for abridgement of the right. We observe at the outset that exhaustion of state administrative remedies is not ordinarily a prerequisite to commencing a § 1983 action. *Patsy v. Board of Regents*, 457 U.S. 496, 507-12 (1986). *Patsy* does not, however, displace the holding of *National Sea Clammers*, 453 U.S. at 13-14, that the constellation of enforcement mechanisms, administrative and otherwise, available under a federal statute may be so elaborate as to evince a congressional intent to bar additional judicial remedies. We believe that the enforcement mechanisms under the Medicaid Act evince no such intent, and hold that VHA is not foreclosed from seeking redress through a § 1983 proceeding.⁷

⁶ The court in *Pennhurst* "assume[d] that Congress will not implicitly attempt to impose financial obligations on the state." 451 U.S. at 17. It seems equally reasonable for us to assume that Congress would not, as it has in the Hill-Burton Act, 42 U.S.C.A. § 291 *et seq.* require many VHA members to participate in the Virginia Plan but implicitly deny the members an enforceable right to reimbursement rates that meet their costs.

⁷ We recognize amici's concerns that authorizing § 1983 actions to redress grievances against State reimbursement systems subverts Congressional intent to give State administrators sole jurisdiction over such grievances and invites a multiplicity of suits burdensome both to State Attorneys General and to the federal courts. We have dealt at length, and shall do so further, with the first concern. As to the second, we note that while the Supreme Court in *Pennhurst* indicated that the foreseeability and financial consequences to the States of recognizing an implied right of action may properly influence our decision, 451 U.S. at 24-25, we have not found authority instructing us to account for the threat of burdensome litigation when analyzing a claim of an implied right of action. To the extent this appeal sheds light on that concern, though, we believe it assuages it. We indicate below that *stare decisis* may foreclose litigation of issues in this case, and can foresee that *stare decisis* or res judicata resulting from this challenge to Virginia's system may obtain in future similar actions brought by VHA or its members. Also, of course, the Virginia providers' election to claim through VHA seems to allay, rather than heighten, the concern that this action augurs numerous suits by single or small groups of providers.

The burden is on Virginia to "demonstrate . . . by express provision or other specific evidence from the statute itself that Congress intended to foreclose such private enforcement." *Wright v. City of Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 423 (1987); see also *Smith v. Robinson*, 468 U.S. 992, 1011-12 (1984). *National Sea Clammers*, 453 U.S. at 13. Congress has not expressly foreclosed private enforcement of the Act. We agree with the district court that Virginia has not satisfied its burden of showing an implied intent to foreclose private judicial enforcement.

The Act lacks any provision for a judicial remedy. The Supreme Court has found such a lack a strong indicium of an intent not to foreclose. *Wright*, 479 U.S. at 427; *Smith*, 468 U.S. at 1011; *National Sea Clammers*, 453 U.S. at 14-17.

The Secretary, through the Health Care Financing Administration ("HCFA"), possesses some authority to review State plans. As we have noted, § 1396a(a)(13)(A) requires State assurances "satisfactory to the Secretary." 42 U.S.C.A. § 1396a(a)(42) empowers the Secretary to audit state plans as necessary to insure proper reimbursement. 42 U.S.C.A. § 1396c allows the Secretary to withdraw federal funds from states found not in compliance.

In *Wright*, however, the court found federal agency "authority to audit, enforce . . . contracts, and cut off federal funds . . . [to be] generalized powers . . . insufficient to indicate a congressional intention to foreclose § 1983 remedies." 479 U.S. at 428.⁸ Also similar to the facts of *Wright* is the apparent absence of any formal mechanism by which providers may bring complaints about state Medicaid administration to the Secretary's attention. *Id.*

The Medicaid Act is not, however, the exclusive source of oversight mechanism. Virginia has established an administrative appeals mechanism whereby VHA and its members may air at least some of their

⁸ We assume, as Virginia argues, that HCFA has vigorously exercised its enforcement power. We also agree with Virginia that in *Phelps v. Housing Auth. of Woodruff*, 742 F. 2d 816, 821 (4th Cir. 1984), we gave substantial weight to a federal agency's vigorous exercise of its audit power and to its authority to withhold funds in concluding that a statute foreclosed private enforcement. We believe that *Wright*, decided after *Phelps*, requires us to give less weight to the Act's oversight provisions and the Secretary's vigor in assessing whether Virginia has met its burden than *Phelps* gave to HUD's authority.

grievances.⁹ The Supreme Court has instructed us, though, that "the existence of a state administrative remedy does not ordinarily foreclose resort to § 1983." *Wright*, 479 U.S. at 427-28 (citing *Patsy*, 457 U.S. at 516). Nor does *Wright* suggest that we should somehow amalgamate federal and state remedial mechanisms in considering foreclosure. *See also National Sea Clammers* 453 U.S. at 17 (focusing on remedies "expressly provided by Congress."). Even if amalgamation were correct, we do not believe the mechanisms together amount to a congressionally-directed remedial scheme so comprehensive as to foreclose a private judicial remedy.

III.

We next consider whether the district court was correct to refuse Virginia's request for summary judgment based on *stare decisis*. Virginia contends that the district court's decision in *Mary Washington Hospital Inc. v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985), an action brought by a single VHA member hospital against various DMAS officials, has addressed all of the allegations raised here by VHA.¹⁰ The district court declined to conclude that *stare decisis* warranted dismissal at this stage, but recognized that *stare decisis* may well apply to issues as they crystallize through further proceedings. We affirm, based on our conclusion that the reimbursement system has changed since the decision in *Mary Washington*, but emphasize our approval of the district court's willingness to revisit the issue as seems appropriate.

The district court in *Mary Washington* described the case as a challenge by a provider of "the failure of Virginia's [reimbursement] system to take into account [the hospital's location] and other factors

⁹ Virginia promulgated its appeals mechanism not in response to the Medicaid Act itself, but to a regulation promulgated thereunder by the HCFA. The regulation states, "The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative reviews, with respect to such issues as the agency determines appropriate, of payment rates." 42 C.F.R. § 447.253(c).

Notably, the regulation appears not to authorize appeals by class representatives such as VHA. The regulation also leaves to State discretion what issues to entertain. Counsel for VHA stated at oral argument what we understand Virginia not to have disputed, that the Virginia Plan's appeals system would refuse to consider certain of the allegations raised in VHA's complaint.

¹⁰ Because the parties had not then presented the issue, we expressly refrained from considering the *stare decisis* implications of *Mary Washington* in our earlier visit to this case. *Baliles*, 830 F.2d at 1311 n.3.

that allegedly affected its costs of efficient operation." 635 F. Supp. at 896. The provider had also challenged "the use of the [consumer price index] as the reimbursement escalator and particularly the failure of the system to recognize increases in operating costs resulting from the addition of new and necessary services." *Id.* The court also observed "that the potential future inadequacy of Virginia's rates under the current system is not now a properly justiciable issue". *Id.* at 901. It is, of course, precisely this issue that VHA seeks to litigate in this action.

The decision in *Mary Washington* was sufficiently fact specific, and the holdings there sufficiently distinct from what would have been dispositive here, that there were not clear bases on which to dismiss VHA's action outright. It is true that *Mary Washington* upheld all aspects of the Virginia plan save its appeals mechanism. Virginia has since promulgated a new appeals mechanism, and now employs a different reimbursement escalator. It was not error for the district court to identify differences between *Mary Washington* and this case sufficient to justify allowing VHA to proceed further.

IV.

We now address the remainder of the arguments Virginia has presented in favor of nonjusticability.

A.

The correct analysis of Virginia's contention that the Eleventh Amendment bars VHA's suit is set forth in *Ex parte Young*, 52 L.Ed. 714 (1908), and its progeny. *Ex parte Young* recognized an exception to the States' Eleventh Amendment immunity for suits that charge state officials with violations of federal law and request prospective relief. We note first that VHA has requested no retroactive monetary relief, and has named as defendants not the Commonwealth itself or any of its agencies or departments, but only certain Commonwealth officials. *See Papasan v. Allain*, 92 L.Ed.2d 209, 226-27 (1986).

Virginia nonetheless asserts that the Commonwealth is the "real party in interest" to the action and that VHA seeks disguised monetary relief in the form of higher reimbursement rates. Virginia is, of course, correct to some extent, but has nonetheless failed to identify why the case is not within the *Ex parte Young* exception. A suit against Virginia officials for actions done in obedience to Commonwealth law naturally interests the Commonwealth, but is just the sort of action *Ex parte Young* authorized. The Supreme Court has also repeatedly recognized

that "relief that serves directly to bring an end to a present violation of federal law is not barred by the Eleventh Amendment even though accompanied by a substantial ancillary effect on the state treasury." *Papasan*, 92 L.Ed.2d at 227; see also *Milliken v. Bradley*, 53 L.Ed.2d 745 (1977); *Edelman v. Jordan*, 39 L.Ed.2d 662 (1974). We believe the district court correctly held this action not barred by the Eleventh Amendment.

B.

VHA claims associational standing in behalf of its member hospitals. The standard is whether: (1) the members otherwise have standing; (2) the interest VHA seeks to promote is germane to its purpose;¹¹ and (3) neither the claims asserted nor the relief requested require the participation of member hospitals. *Coles v. Havens Realty Corp.*, 633 F.2d 384, 390 (4th Cir. 1980) (citations omitted) aff'd in part, rev'd on other grounds sub nom., *Coleman v. Havens Realty Corp.*, 455 U.S. 363 (1982). The district court found Virginia to have disputed only the third *Coles* criterion, and concluded that VHA was challenging conduct affecting its members generally and that VHA's claim for equitable relief was less likely to require members' participation than would a damages action. The court indicated, however, that it would be willing to reconsider if evidence surfaced that lent further support to Virginia's characterization.

Virginia here argues that the district court incorrectly assessed the evidence on the third *Coles* criterion. Virginia also contends that VHA had no direct or proprietary interest in the adequacy of Medicaid rates and so has no interest sufficient to create a case or controversy with Virginia. Cf. *Baliles*, 830 F.2d at 1315 (Phillips, J., dissenting) ("The standing issue is critically related to the collateral estoppel issue in ways that might well force VHA into somewhat conflicting positions on the nature and degree of the associational relationships here at issue.") We believe, given the district court's resolution of the first two *Coles* criterion and Virginia's failure to submit new evidence on either, that there is little substance to the case or controversy argument. While there may be some inconsistency between allowing VHA to escape the collateral estoppel effects of one of its member's litigation and recognizing VHA's ability to litigate in its members' behalf, we believe VHA satisfies the *Coles* criterion.

¹¹ According to its complaint, VHA's purpose is "developing and improving the hospital industry in Virginia."

Virginia argues that the district court will have to examine data and make findings for each VHA member hospital in order to resolve VHA's claims and, if appropriate, to grant the requested relief. If this were right, or if it appeared to be so at this stage, Virginia might be correct that VHA fails to satisfy the third *Coles* criterion. We think though, that Virginia's argument is not now valid.

As the district court observed, VHA "asserts it is challenging factors common to all of the hospitals." VHA's claims are against the Virginia Plan, and it has requested relief that would result in the reform of the plan. While reform certainly affects each member hospital, and may at some point require proceedings directed toward sets of providers smaller than VHA, VHA has not requested that the district court do anything but consider the plan. Virginia has not made clear why the district court must necessarily inquire into the affairs of each provider or of smaller groups of providers to do what VHA requests, and we find no evidence in the pleadings or elsewhere that suggests trial or an order in favor of VHA would require findings specific to its individual members. We therefore believe the district court was correct to recognize VHA's standing at this stage, although we endorse the court's willingness to revisit this issue if further progress reveals evidence that VHA should not have standing to proceed alone.

C.

The parties agree that the pertinent limitations period is two years. They also agree that VHA's cause of action first arose on July 1, 1982, when Virginia enacted its current reimbursement plan. VHA filed its complaint on March 19, 1986. The district court found that VHA had alleged an ongoing constitutional violation, and that the statute would not have begun to run until the violation ended. We believe this was correct.

Virginia argues that the district court's decision would nullify all statutes of limitation with respect to statutory challenges. The district court, however, held only that "[t]he continued enforcement of an unconstitutional statute cannot be insulated by the statute of limitations", a holding in line with appellate precedent. *Brown v Board of Education*, 347 U.S. 483 (1954); *Eldridge v. Bouchard*, 645 F. Supp. 749 (W.D. Va. 1986), aff'd 823 F.2d 546 (4th Cir. 1987); *Long v. Florida*, 805 F.2d 1542, (11th Cir. 1986), cert. denied, 108 S. Ct. 78 (1987).

Virginia's subsidiary argument, that the statute of limitations should bar VHA from suing based on conduct after March 19, 1984, seems to

repeat its principal argument, and to fail for the same reason. Virginia recognizes that a partial bar would preclude a challenge to the entire reimbursement system and limit the issues to the validity of relatively minor or as-yet-unimplemented aspects of the system. This is patently incompatible with the district court's holding that the limitations period cannot protect an allegedly unconstitutional program.

D.

The district court determined that VHA's claims were ripe as essentially legal products of final agency action and because of the hardship delay would produce.¹² *Abbott Laboratories v. Gardner*, 387 U.S. 136, 169 (1967). The Court found the Virginia plan to have operated for several years, making its enforcement not a matter of speculation. VHA's claim of deficient reimbursement rates presents a purely legal issue. Because VHA challenged the system and not individual providers' reimbursement rates, the court found inapposite Virginia's contention that providers should first have to appeal through the plan's administrative apparatus.

Toilet Goods Ass'n v. Gardner, 387 U.S. 258 (1967), on which Virginia relies heavily, supports the district court's decision. In *Toilet Goods*, a group of cosmetics manufacturers challenged an FDA regulation allowing unannounced inspections of the manufacturers' plants. The FDA had not yet applied its regulation, and the Court found its effect therefore speculative. 387 U.S. at 164. In this case, VHA has levied a challenge to a system that has operated for some years and the products of which, the reimbursement rates, VHA believes inadequate. Although no VHA member hospital has prosecuted its case through the administrative appeal mechanism, this mechanism is also the subject of VHA's challenge. VHA has framed its suit as a denial of the legitimacy of the entire Virginia plan. We think the district court was correct to hold that the effects of this system are now sufficiently clear to defeat an argument that VHA's suit is premature.

¹² In *Randall v. Lukhard*, 709 F. 2d 257 (4th Cir. 1983), relevant holdings adopted on rehearing en banc, 729 F.2d 966 (4th Cir.), cert. denied, 469 U.S. 872 (1984), we held that for statute of limitations purposes the date on which the plaintiffs' cause of action arose was that of the "final unfavorable administrative action" revoking eligibility for Medicaid. 709 F.2d at 262 n.7. In *Randall*, we considered whether the Commonwealth of Virginia had properly denied Medicaid benefits to a number of individual claimants. The discrimination action in *Randall* was a matter of history and not as in this case, a practice that continues as a matter of settled state policy and that affects plaintiffs still involved in the Medicaid system. We therefore perceive no incompatibility between *Randall* and our resolutions of the statute of limitations and ripeness issues in this case.

Toilet Goods also supports VHA's position on hardship. In *Toilet Goods*, the Court found the burdens of preliminary compliance and of piecemeal administrative challenges a sufficient hardship to satisfy a ripeness test. 387 U.S. at 173-74. Here, VHA alleges that its members' reimbursement rates and opportunity for redress through the administrative apparatus are inadequate. Delay would increase the costs to VHA members, costs the Eleventh Amendment will likely bar them from recovering through a federal suit. VHA members are, moreover, legally obliged to treat Medicaid patients no matter the members' reimbursement rates. For these reasons, we think VHA has shown sufficient hardship to satisfy the *Abbott Laboratories* test.

E.

Virginia believes the district court should have abstained under either *Burford v. Sun Oil Co.*, 319 U.S. 315 (1943) or *Railroad Comm'n of Texas v. Pullman Co.*, 312 U.S. 496 (1941). The district court gave brief attention to the *Pullman* doctrine, finding little to indicate that it applied. We believe this was correct. *Pullman* abstention is appropriate in a case that involves unsettled issues of state law, the erroneous resolution of which by the federal court would trouble all concerned. This case does not appear to present any unsettled issues of Commonwealth law save, perhaps, the necessity of appealing administratively before suing in federal court. As we have written earlier, we think there is no such necessity here.

In *Burford*, the Court held that it was proper for a federal court to abstain from deciding a challenge to an oil field proration order issued by a Texas regulatory commission. The Court reasoned that the proper allocation of oil resources was a matter of substantial state concern, for which the state had set up a comprehensive regulatory scheme; that there was a significant need for uniform decision-making in the area, which the state had attempted to provide by consolidating review of all claims involving oil allocation in specialized state courts; that the intervention of the lower federal courts would create precisely the sort of disuniformity that the state system was designed to avoid; and that the state courts could adequately vindicate the federal rights at issue. 319 U.S. at 327-34. Under such circumstances, the Court held, fundamental principles of comity require the federal courts to stay their hand.

The district court found that the Virginia plan was not the sort of comprehensive regulatory system it was bound to respect through abstention. The court also found that VHA could not have prosecuted its

federal claims through the administrative appeals apparatus, and that the Medicaid Act revealed Medicaid to be the subject of both state and federal concern. *Curtis v. Taylor*, 648 F.2d 946, 949 (5th Cir. 1980). In short, the district court found little that dovetailed with the *Burford* rationale for abstention. We think this was fairly plainly correct.

v.

For the reasons stated above, the district court's order denying Virginia's motion for summary judgment is affirmed.

AFFIRMED.

FILED
Mar. 22, 1989
U.S. Court of Appeals
Fourth Circuit

**UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT**

NO. 88-1306

THE VIRGINIA HOSPITAL ASSOCIATION

Plaintiff-Appellee.

v.

GERALD BALILES, etc., et al.

Defendants-Appellants.

On Petition for Rehearing with Suggestion for Rehearing In Banc

The appellants' petition for rehearing and suggestion for rehearing in banc were submitted to this Court. As no member of this Court or the panel requested a poll on the suggestion for rehearing in banc, and

As the panel considered the petition for rehearing and is of the opinion that it should be denied.

IT IS ORDERED that the petition for rehearing and suggestion for rehearing in banc are denied.

Entered at the direction of Chief Judge Ervin, with the concurrence of Judge Russell and Judge Kiser, United States District Judge sitting by designation.

For the Court

JOHN M. GREACEN
CLERK

FILED
Mar. 29, 1989
U.S. Court of Appeals
Fourth Circuit

**UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT**

NO. 88-1306

THE VIRGINIA HOSPITAL ASSOC..

Plaintiff-Appellee.

v.

GERALD BALILES, et al.

Defendants-Appellants.

Appeal from the United States District Court for the Eastern District of Virginia, at Richmond. Robert R. Merhige, Jr., District Judge.

Upon consideration of a motion of the appellants that the mandate be stayed pending application to the United States Supreme Court for a writ of certiorari,

IT IS ORDERED that the motion is denied.

For the Court - By Direction.

JOHN M. GREACEN
CLERK

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION**

THE VIRGINIA HOSPITAL ASSOCIATION,)
Plaintiff,)
v.) Civil Action No.
GERALD L. BALILES, et al.,) 86-0166-R
Defendants.)

ORDER

The Court is in receipt of defendants' motion for summary judgment and plaintiff's cross-motion for summary judgment on the issues raised in defendants' motion. By Order dated March 25, 1988, the Court denied defendants' motion. The Court now provides in the accompanying memorandum the reasons behind said Order. Because the disposition of defendants' motion effectively rules on plaintiff's motion, no further Order is required.

The Court finds that the disposition of defendants' motion involves controlling questions of law as to which there are substantial grounds for differences of opinion and that an immediate appeal from this Order and the Order of March 25, 1988 may materially advance the ultimate termination of the litigation. Accordingly, it is ADJUDGED and ORDERED that defendants' motion to certify issues for interlocutory appeal pursuant to 28 U.S.C. § 1292(b) is GRANTED.

Let the Clerk send a copy of this Order and the Memorandum to counsel of record.

/s/ ROBERT R. MERHIGE, JR.
UNITED STATES DISTRICT JUDGE

Date May 18, 1988

**IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION**

THE VIRGINIA HOSPITAL ASSOCIATION,)
Plaintiff,)
v.) Civil Action No.
GERALD L. BALILES, et al.,) 86-0166-R
Defendants.)

MEMORANDUM

This matter came before the Court on defendants' motion to dismiss or for summary judgment. By Order dated March 25, 1988, the Court denied defendants' motion. On March 30, 1988, defendants moved to certify issues for interlocutory appeal. In order to facilitate defendants' contemplated appeal, the Court hereby states the reasons behind the March 25, 1988 Order. Jurisdiction is premised on 28 U.S.C. §§ 1331 and 1333.

Background

Plaintiff Virginia Hospital Association (VHA) is a non-profit organization whose members include Virginia hospitals. Its alleged purpose is improving the hospital industry in Virginia. Defendants are officials in the government of the Commonwealth of Virginia and include the Governor, Secretary of Human Resources, Director of Medical Assistance Services and members of the Board of Medical Assistance Services.

VHA brought this action challenging Virginia's procedures for reimbursing hospitals for costs associated with the Medicaid program ("Virginia Plan"). In Count I, plaintiff seeks a declaration that the Virginia plan violates the Medicaid Act, 42 U.S.C. § 1396 *et seq.*, and therefore also violates the Supremacy Clause. In Count II, VHA seeks a declaration that the Virginia Plan violates due process. In Count III, VHA requests that the Court permanently enjoin enforcement of the Virginia Plan.

On September 22, 1986, this Court granted summary judgment for defendants on the ground that VHA was collaterally estopped from litigating issues previously decided by this Court in *Mary Washington Hospital, Inc. v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985). The Fourth Circuit reversed and remanded. *Virginia Hospital Association v. Baliles*, 830 F.2d 1308 (4th Cir. 1987).

Discussion

Defendants have moved for summary judgment on eight grounds.

I. Eleventh Amendment Bar

Defendants assert that the Eleventh Amendment to the United States Constitution bars plaintiff's claims. The Eleventh Amendment, of course, limits the type of relief that can be recovered from a state.

While the development of Eleventh Amendment jurisprudence has been complex, the Supreme Court recently has clearly delineated the scope of such immunity. In *Papasan v. Allain*, the Court explained as follows:

Relief that in essence serves to compensate a party injured in the past by an action of a state official in his official capacity that was illegal under federal law is barred even when the state official is the named defendant. This is true if the relief is expressly denominated as damages. It is also true if the relief is tantamount to an award of damages for a past violation of federal law, even though styled as something else. On the other hand, relief that serves directly to bring an end to a present violation of federal law is not barred by the Eleventh Amendment even though accompanied by a substantial ancillary effect on the state treasury.

106 S.Ct. 2932, 2940 (1986) (citations omitted).

By the express terms of its complaint, VHA purports to seek an end to a present violation of federal law. As relief, VHA seeks to enjoin operation of the Virginia Plan in the future. The Court finds no indication of a disguised attempt to recover damages for an injury in the past. While the relief sought would have substantial ancillary effect on the state treasury, such relief is not barred by the Eleventh Amendment. Accordingly, defendants's motion for summary judgment on this ground must be denied.

II. Standing

Defendants challenge VHA's standing to bring this action. Plaintiff asserts it has representative or associational standing.

The test for associational standing is as follows:

- [A]n association has standing to bring suit on behalf of its members when:
- (a) its members would otherwise have standing to sue in their own right;
 - (b) the interest it seeks to protect are germane to the organization's purpose; and
 - (c) neither the claim asserted nor the relief requested requires the participation of individual members in the lawsuit.

Coles v. Havens Realty Corp., 633 F.2d 384, 390 (4th Cir. 1980) (quoting *Hunt v. Washington Apple Advertising Commission*, 432 U.S. 333 (1977)), modified sub. nom., *Havens Realty Corp. v. Coleman*, 455 U.S. 363 (1982).

Defendants do not appear to dispute the existence of the first two components. Defendants, however, assert that the nature of the case requires the participation of VHA's individual members. Defendants characterize the lawsuit as a group appeal of individual hospital reimbursement rates.

In contrast, plaintiff asserts it is challenging factors common to all of the hospitals. Accordingly, individual participation would not be required. Moreover, plaintiff seeks equitable relief, which is less likely to require individual participation than if damages were sought.

At this time, the Court is inclined to agree with plaintiff. Accordingly, defendants' motion for summary judgment on this ground must be denied. However, if at some later date the Court discovers that defendants' characterization of this suit is accurate, the Court will reconsider the issue.

III. Enforceable Right

Defendants contend that the substantive enforceable rights, if any, under the Medicaid Act are conferred on Medicaid recipients, not health care providers. Thus, while a recipient may bring an action under the Medicaid Act, see *Schweiker v. Hogan*, 457 U.S. 569 (1982), defendants contend that a health care provider may not.

The Court finds defendants' argument without merit. The Medicaid Act provides that a "State plan for medical assistance must . . . provide for payment . . . of the hospital, skilled nursing facility, and intermediate care facilities . . ." 42 U.S.C. § 1396a(a)(13)(A). Accordingly, health care providers directly and expressly benefit from the Medicaid Act.

"[C]ourts . . . permit[ting] providers to bring actions to enforce the Medicaid statutes . . . have recognized that Medicaid patients and health-care providers have parallel interests with respect to Medicaid funding and reimbursement." *Coos Bay Care Center v. Oregon*, 803 F.2d 1060, 1063 (9th Cir. 1986), cert. granted, 107 S.Ct. 1970, vacated as moot, 108 S.Ct. 52 (1987). No significant distinction can be made between recipients and providers with respect to their ability to enforce the act. *Massachusetts General Hospital v. Sargent*, 397 F. Supp. 1056, 1059 (D. Mass. 1975).

Defendants' reliance on *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981) is misplaced. In *Pennhurst*, a class of mentally retarded persons claimed they had a right to better state-funded accommodations under the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6000, et seq. The Court examined said Act and found it spoke merely in precatory terms. *Id.* at 18. That is, providing a certain level of accommodations was not a condition to the state receiving federal funds. *Id.* at 17-18. Here, by contrast, "each state participating in the Medicaid program *must* reimburse hospitals at rates set by the state that are reasonable and adequate." *Virginia Hospital Association*, 830 F.2d at 1310 (emphasis added).

Accordingly, defendants' motion for summary judgment with respect to this issue must be denied.

IV. Foreclosure

Defendants contend that the remedial scheme provided by the Medicaid Act forecloses a private remedy under 42 U.S.C. § 1983.

"[I]f there is a state deprivation of a "right" secured by a federal statute, § 1983 provides a remedial cause of action unless the state actor demonstrates by express provision or other specific evidence from the statute itself that Congress intended to foreclose such private enforcement." *Wright v. Roanoke Redevelopment and Housing Authority*, 107 S.Ct. 766, 771 (1987). The state actor may overcome its burden by demonstrating that the statute's remedial devices are "sufficiently comprehensive and effective to raise a clear inference that Congress intended to foreclose a § 1983 cause of action." *Id.*

Defendants cannot claim that Congress expressly foreclosed private enforcement of the Medicaid Act. Instead, defendants contend the Medicaid Act contains a comprehensive scheme of enforcement. These provisions include: a requirement that the state make assurances to the Secretary of Health and Human Services (the "Secretary") that the rates are reasonable, 42 U.S.C. § 1396a(a)(13)(A); a directive that the Secretary approve any plan that fulfills the conditions listed in the Act, 42

U.S.C. § 1396a(b); and a provision that the records of participating entities may be audited if the Secretary finds an audit necessary. 42 U.S.C. § 1396a(a)(42).

The Court finds that these generalized powers are not sufficiently comprehensive and effective to demonstrate that Congress intended to foreclose private remedies. *Cf. Wright*, 107 S.Ct. at 773. Accordingly, defendants' motion for summary judgment on this issue must be denied.

V. Statute of Limitations

The parties agree that the relevant statute of limitations is two years. They disagree, however, over when the cause of action accrued.

Defendants assert that, since plaintiff purports to make a facial challenge to the Virginia plan, the claim accrued when the enacted scheme became effective on July 1, 1982. Plaintiff asserts that it is challenging the enactment, enforcement and implementation of the Virginia Plan. Each time its members are injured, it argues, the limitation period begins anew.

The Court agrees with plaintiff. The continued enforcement of an unconstitutional statute cannot be insulated by the statute of limitations. See generally *Brown v. Board of Education*, 347 U.S. 483 (1954); *Eldridge v. Bouchard*, 620 F. Supp. 678 (W.D. Va. 1985). Accordingly, defendants' motion for summary judgment on this ground must be denied.

Stare Decisis

Defendants correctly assert that *Mary Washington* will have a stare decisis effect on the disposition of this case. However, that cannot be grounds for dismissal at this stage of the litigation. If it were so, the limitations on the res judicata doctrine would be rendered meaningless. See 1B J. Moore, J. Lucas, T. Currier, *Moore's Federal Practice* ¶ 0.402[2] (2d ed. 1984) ("[A] [stare decisis] theory under which a judgment in one case inexorably determines the judgment in another indistinguishable on its substantive facts would confuse the principle of stare decisis with those of res judicata. Even as applied to decisions of the trial court, such a theory would result in foreclosing issues of law not raised or considered in the previous decision, though the parties to the second case are not bound by the first judgment").

Accordingly, defendants' motion for summary judgment on this issue must be denied.

VII. Ripeness

Defendants again characterize this lawsuit as a group appeal of individual rates. They assert that, since the administrative appeals have not been taken and/or finalized, this action is not ripe.

In determining whether a challenge to an administrative regulation is ripe for review, a twofold inquiry must be made. *Toilet Goods Association, Inc. v. Gardner*, 387 U.S. 158, 162 (1967). First, the Court must determine whether the issues tendered are appropriate for judicial resolution. *Id.* With regard to this factor, the Court should consider whether the questions presented are legal ones. *Abbott Laboratories v. Gardner*, 387 U.S. 136, 149 (1967). The Court might also examine whether the manner of enforcing the regulations is still speculative. See *Toilet Goods*, 387 U.S. at 162-64. Second, the Court should assess the hardship to the parties if judicial relief is denied at that stage. *Id.* at 162.

Under these tests, the Court finds that the challenge is not premature. The rate calculation regulations have been in effect for several years, so that their manner of enforcement is not speculative. Moreover, the primary allegation in the complaint is that the method used to calculate rates is legally defective—certainly, a legal question. Furthermore, if plaintiff is entitled to relief, delay causes it further hardship. Thus, both the fitness and hardship factors are present.

Defendants assert that the action is not ripe because plaintiff's members have not appealed administratively their individual rates. While defendants might prevail on this argument if this were a group appeal of individual rates, that appears not to be the case here. Plaintiff is challenging the system, not the individual rates. Again, as with the standing question, the Court may reconsider this issue if the Court later determines that defendants' characterization of the lawsuit is correct.

VIII. Abstention

Defendants urge the Court to abstain under *Burford v. Sun Oil Co.*, 319 U.S. 315 (1943). *Burford* involved state regulation of oil and gas fields which, as the Court found, "must be regulated as a unit for conservation purposes." *Id.* at 319. Inconsistent decisions had been creating incompatible standards of behavior. *Id.* at 329-30. The state, therefore, provided a unified method of regulating this natural resource through administrative and judicial review. *Id.* at 333-34. Consequently, the Court found it appropriate to abstain.

Defendants have not convinced the Court that abstention is appropriate here. The state has not developed a comprehensive regulatory scheme that would address plaintiff's challenges. *Cf. Wright*, 107 S.Ct. at 773. If the issues cannot be raised in the state administration procedure, there is no need to abstain. *Curtis v. Taylor*, 648 F.2d 946,

949 (5th Cir. 1980). Moreover, by enacting the Medicaid Act, the federal government has determined that this is not solely a state concern.

Accordingly, summary judgment on this ground will be denied.

An appropriate Order shall issue.

/s/ ROBERT R. MERHIGE, JR.
UNITED STATES DISTRICT JUDGE

Date May 18 1988

(2)
No. 88-2043

Supreme Court, U.S.
F I L E D
JUL 29 1988
JOSEPH F. SPANIOL, JR.

IN THE
Supreme Court of the United States

October Term, 1988

GERALD L. BALILES, *et al.*,

Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

On Petition for a Writ of Certiorari to the United States
Court of Appeals for the Fourth Circuit

RESPONDENT'S BRIEF IN OPPOSITION

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5188

QUESTIONS PRESENTED

1. Whether health care providers have a private right under 42 U.S.C. § 1983 to enforce provisions of the Medicaid Act requiring reasonable and adequate payment for provider services.
2. Whether the *Ex Parte Young* rule applies to this suit for prospective declaratory and injunctive relief against state officials.
3. Whether the state statute of limitations on 42 U.S.C. § 1983 actions bars this suit against state officials for a continuing violation of federal law in enacting, enforcing, and implementing the Medicaid Reimbursement System and Appeals System.
4. Whether Burford abstention should stay federal court review of the Virginia Medicaid Program's noncompliance with federal law requirements.

Pursuant to the requirements of Rule 28.1 of the United States Supreme Court, the affiliates of the Virginia Hospital Association ("VHA") are as follows:

Virginia Hospital Shared Services Corporation
Virginia Hospital Research and Education Foundation
Virginia Hospital Employee Benefits Trust

The VHA has no parent corporation or subsidiaries.

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NO. 88-2043

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1988

GERALD L. BALILES, et al.,

Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE
JUDGMENT OF THE UNITED STATES COURT OF
APPEALS FOR THE FOURTH CIRCUIT

The Virginia Hospital Association ("the VHA"), appellee below, hereby submits its brief in opposition to the Petition for Writ of Certiorari filed in this Court. The petition, filed by the state officials ("the defendants") in this case, seeks review of the decision

of the United States Court of Appeals for the Fourth Circuit on four issues.

I.

OPINIONS BELOW

The VHA adopts the appendix designations used by the defendants for the relevant opinions and orders entered below. The defendants' Memorandum in Support of the Commonwealth's Motion for Stay of Further Proceedings in the United States District Court for the Eastern District of Virginia, Richmond Division, dated April 18, 1989, is set forth in Appendix E herein.

II.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

In addition to the Eleventh Amendment provisions included in

defendants' petition, this case also involves the construction and application of 42 U.S.C. § 1983, which reads as follows:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a state of the District of Columbia.

This case also involves the application of Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. ("the Medicaid Act"). The relevant provision of the Medicaid Act is 42 U.S.C. § 1396a(a)(13)(A), which reads in its entirety as follows:

A state plan for medical assistance must -- provide for payment (except where the State agency is subject to an order under section 1914) of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State) and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1861(v)(1)(G)), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1861(v)(1)(G)) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, skilled nursing facility, and

intermediate care facility and periodic audits by the State of such reports.

III.

STATEMENT OF THE CASE

The VHA adopts by reference the statement of the case in the Opinion of the United States Court of Appeals for the Fourth Circuit, dated February 22, 1989, reported at 868 F.2d 653 and also set forth in Appendix A, to defendants' petition.

IV.

JURISDICTION OF THE UNITED STATES DISTRICT COURT

The United States District Court for the Eastern District of Virginia, Richmond Division assumed jurisdiction of this matter pursuant to 28 U.S.C. §§ 1331 and 1343. App. at D-2.

**REASONS WHY THE PETITION FOR
CERTIORARI SHOULD BE DENIED**

INTRODUCTION

The defendants have presented four questions¹ in their petition for writ of certiorari, concerning whether health care providers have an enforceable right, actionable under 42 U.S.C. § 1983, to reasonable and adequate payment for services rendered in accordance with the

¹In addition to these issues, the defendants raised below jurisdictional questions concerning the *stare decisis* effect of a prior decision in the District Court and concerning the associational standing of the VHA to assert the rights of its member hospitals. App. at A-5. The Court of Appeals held that the action should not be dismissed based on *stare decisis* and that the VHA did not lack standing. App. at A-12, 13, 14, 15. While the defendants continue to argue these issues in the body of their petition, they have not raised them as questions presented for review and therefore they are not before the Court. Rule 21.1(a), Rules of United States Supreme Court.

requirements of the federal Medicaid statute, whether the defendants are immune from suit under the Eleventh Amendment, whether the action was brought within the applicable statute of limitations and whether the District Court should have abstained from deciding the case. The petition for certiorari should be denied because the Court of Appeals adhered to precedent established by this Court in correctly deciding each of these issues. The Fourth Circuit's opinion is not in conflict with any decision of this Court, nor with any decision of another federal court of appeals on the same matters, nor with a decision of the court of last resort of any state.

Furthermore, the defendants are asking the Court to review an

interlocutory decree of the Court of Appeals. The Court exercises its certiorari jurisdiction sparingly. Nothing about this case is so extraordinary that the Court should abandon its normal practice of denying certiorari when there is no final judgment in the case. An exercise of the Court's discretionary power to review at this point would be premature. Both the District Court and the Fourth Circuit (App. at A-12,14,15) noted that development of the facts at trial would shed light on several of the jurisdictional issues argued by the defendants and evidenced a willingness to revisit these issues if necessary. The VHA believes that the development of a factual record would aid the Court in reviewing the issues raised in the

petition should review be sought after trial.

Finally, following the Court of Appeals decision, the defendants suggested to the District Court in their Memorandum in Support of the Commonwealth's Motion for Stay of Further Proceedings, set out in Appendix E herein, that the state's current study of Medicaid reimbursement rates might well render the litigation moot. Because only prospective relief was requested in this case, there is no need for the Court to grant certiorari when the defendants envision that the litigation may be mooted by their own actions before the case could be heard.

A.

**HEALTH CARE
PROVIDERS HAVE AN
ENFORCEABLE RIGHT TO
PAYMENT AT A
REASONABLE AND
ADEQUATE RATE UNDER
THE MEDICAID ACT.**

The federal circuit courts of appeal that have considered the question whether health care providers have an implied right of action to enforce the provision of the Medicaid Act have uniformly held that such a right exists. In holding that providers have a right of action pursuant to 42 U.S.C. § 1396a(a)(13)(A), the Fourth Circuit came to the same conclusion previously reached by the Tenth and Ninth Circuits. *Colorado Health Care Ass'n v. Colorado Dep't of Social Servs.*, 842 F.2d 1158, 1164 n.5 (10th Cir. 1988); *Coos Bay Care Center v.*

Oregon Dep't of Human Servs., 803 F.2d 1060 (9th Cir. 1986), cert. granted 107 S. Ct. 1970, vacated as moot, 108 S. Ct. 52 (1987). The Tenth Circuit has just recently reaffirmed its earlier ruling that § 1396a(a)(13)(A) creates enforceable rights on behalf of health care providers. *Amisub, Inc. v. Colorado Dep't of Social Servs.*, No. 88-2482, slip op. at 9-11 (10th Cir. July 11, 1989). See also *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291 (8th Cir. 1985) (providers have enforceable rights under the Medicaid Act).

This Court held in *Maine v. Thiboutot*, 448 U.S. 1 (1980) that federal statutes may imply rights actionable under 42 U.S.C. § 1983. The Court of Appeals applied the criteria identified in *Middlesex City Sewerage Authority v.*

National Sea Clammers Association, 453 U.S. 1, 13 (1981) and *Pennhurst State School and Hospital v. Halderman*, 465 U.S. 89 (1981) in determining that 42 U.S.C. § 1396a(a)(13)(A) creates such an enforceable right on behalf of health care providers. The Court of Appeals analyzed the language of the statute and its legislative history in reaching its conclusion that Congress intended that providers have a private cause of action under the Medicaid Act. App. at A-7, 8, 9, 10. See H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess. 962, reprinted in 1981 U.S. Code Cong. & Admin. News 1010, 1324; S. Rep. No. 139, 97th Cong., 1st Sess. 478, reprinted in 1981 U.S. Code Cong. & Admin. News 396, 744.

The purpose of the Medicaid Act is, of course, to provide medical services to

financially needy persons. Congress determined that in order to accomplish this purpose, providers must be paid rates which are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." 42 U.S.C. § 1396a(a)(13)(A). It was never intended that payment for medical services be made directly to Medicaid recipients. Thus, Medicaid providers are the intended and necessary beneficiaries of the payment provisions of the Medicaid Act. Evidently, the defendants are suggesting that, contrary to the express provisions of § 1396a(a)(13)(A), they can pay providers at a rate which is unreasonable and inadequate to meet the costs incurred by efficiently and economically operated

hospitals without being subject to suit for prospective relief under § 1983.

The Court of Appeals also correctly applied the precedents of this Court in determining that Congress did not intend to foreclose a § 1983 remedy for hospital providers. The Medicaid Act does not provide for a private judicial remedy which might otherwise supplant the § 1983 remedy. App. at A-11. Nor is the administrative oversight accorded to the Health Care Financing Administration so comprehensive an enforcement mechanism that it evidences Congressional intent to foreclose a § 1983 remedy. App. at A-10,

11. See *Wright v. City of Roanoke Redevelopment and Hous. Auth.*, 479 U.S. 418, 427-28 (1987). In addition, the Court of Appeals observed that this Court's decision in *Patsy v. Board of*

Regents, 457 U.S. 496, 507-12 (1986) does not require exhaustion of state administrative remedies as a prerequisite to a § 1983 action. App. at A-10.

In short, the Fourth Circuit properly applied the standards enunciated in recent decisions of this Court in determining that the Medicaid Act confers an implied right of action on providers and that no Congressional intent is evident to foreclose this private remedy. This holding accords with the law established by every other federal court of appeals which has considered the question.

B.

THE FOURTH CIRCUIT
PROPERLY APPLIED
THIS COURT'S EX
PARTE YOUNG DECISION
IN THIS CASE.

The Court of Appeals correctly applied this Court's decision in *Ex Parte Young*, 209 U.S. 123 (1908) and its progeny to the VHA's claims against state officials² for violations of federal law. App. at A-13. By seeking only prospective declaratory and injunctive relief requiring those officials to

²The defendants state that the Commonwealth of Virginia has not waived its Eleventh Amendment immunity to Medicaid Act claims in federal court. The instant suit, however, seeks relief against state officials. As noted by this Court last term, the state's immunity is not relevant to the prospective relief sought against officials in such actions. See *Will v. Michigan Department of State Police*, 57 U.S.L.W. 4677, 4680 n.10 (1989)(citing *Ex Parte Young*, 209 U.S. 123, 159-60 (1908) and *Kentucky v. Graham*, 473 U.S. 159, 167 n.14 (1985)).

conform their future conduct to federal law,³ the VHA's suit falls within the exception to the state's Eleventh Amendment immunity which this Court first recognized in *Ex Parte Young* and has continued to recognize in recent rulings. See, e.g., *Papasan v. Allain*, 478 U.S. 265 (1986); *Green v. Mansour*, 474 U.S. 64 (1985).

³Defendants claim that the District Court's decision in *Mary Washington Hospital v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985) and HCFA's "approval" of the Reimbursement System and Appeals System somehow insulates their actions and makes them consistent with federal law. The Court of Appeals, however, both considered and rejected the bases for this argument. App. at A-12, 13 (rejecting defendants' claim to *stare decisis* protection from suit based on the factual claims addressed in *Mary Washington Hospital v. Fisher*; App. at A-8 n.4 (finding, following an extensive statutory and regulatory analysis, that the Secretary of HHS (and therefore HCFA as a subordinate agency) "is not required to consider the reasonableness of Medicaid reimbursement rates paid by the defendants to VHA hospitals, only the adequacy of state assurances."))

Furthermore, the Court has stated that the Eleventh Amendment does not bar relief designed to stop continuing violations of federal law even if there will be a substantial ancillary impact on the state treasury. See *Papasan v. Allain*, 478 U.S. at 282. As this Court noted in *Green*, a case seeking declaratory relief for a past violation of federal law, "the availability of prospective relief of the sort awarded in *Ex Parte Young* gives life to the Supremacy Clause. Remedies designed to end a continuing violation of federal law are necessary to vindicate the federal interest in assuring the supremacy of that law." 474 U.S. at 68 (citing *Pennhurst State School and Hosp. v. Halderman*, 465 U.S. 89, 102 (1984)). Defendants' continuing violation of

federal law is a federal concern subject to prospective relief. Based on defendants' theory, their actions, no matter how egregious, would be shielded from federal court scrutiny.⁴

"Defendants' claim to "good faith immunity" for their actions completely lacks merit. This issue was neither pleaded, argued, nor briefed below and should not be heard on interlocutory appeal as a matter of law. *Miree v. DeKalb County*, 433 U.S. 25, 34 (1977). The defendants' alleged good faith presents a factual issue which has not been addressed by the lower court and cannot be properly assessed in the absence of factual findings by the District Court. Even if the defense was properly presented, the defendants' sole authority that this Court should apply good faith immunity in this case is completely inapposite. In *Mitchell v. Forsyth*, 472 U.S. 511 (1985), this Court found that the Attorney General of the United States had qualified immunity to suits brought by the victims of federal wiretapping for actions taken prior to a change in the wiretapping laws. Unlike the instant case, there was no continuing violation of law. Most importantly, *Mitchell v. Forsyth* presented a damages claim, not a claim for injunctive relief. Good faith immunity has no application where damages are not at issue. Cf. *Maria Santiago v. Corp. de Renovacion Urbana y Vivienda*, 554 F.2d 1210 (1st Cir. 1977).

C.

THE COURT OF APPEALS
WAS CORRECT IN
FINDING THAT THE
STATUTE OF
LIMITATIONS DOES NOT
BAR THIS SUIT.

The Court of Appeals ruled that VHA allegations of a continuing violation of federal law were not time barred. App. at A-15, 16. This ruling involved a straightforward application of this Court's decision in *Brown v. Board of Education*, 347 U.S. 483 (1954). The VHA has alleged that, in "enacting, enforcing and implementing" the Virginia Medicaid Program, the defendants have violated, and continue to violate, federal law. The Court of Appeals found that a challenge to the continued operation of an unconstitutional Medicaid program cannot be barred by any statute of

limitations. App. at A-15. The defendants offer no authority to the contrary.

In an effort to create a statute of limitations question, the defendants argue that the VHA's claims are somehow time barred based on the *stare decisis effect*⁵ of *Mary Washington Hospital v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985), petition at 12, n. 9, and the VHA's alleged lack of sufficient interest in the outcome of the litigation to meet

⁵The Court of Appeals properly found the District Court decision in *Mary Washington Hospital v. Fisher* to be sufficiently fact-specific and the holdings therein sufficiently distinct from what would be dispositive in this case to deny defendants' motion for summary judgment. App. at A-12. In fact, the District Court's decision in *Mary Washington Hospital* recognized that future developments might take the Virginia Medicaid Program out of compliance with federal law. App. at A-13 (citing *Mary Washington Hospital*, 635 F. Supp. at 901). Those developments have occurred.

this Court's test for associational standing to raise the claims of its members.⁶ Petition at 12, n.10. Cf. *Hunt v. Washington State Apple Advertising Comm'n*, 432 U.S. 333 (1977); *Coles v. Harris Realty Corp.*, 633 F.2d 384 (4th Cir. 1980), modified *sub nom.* *Havens Realty Corp. v. Coleman*, 455 U.S. 363 (1982). The court below addressed both

⁶The defendants have sought to distinguish the applicable limitations period in the instant case from this Court's earlier decision in *Brown v. Board of Education* by asserting that the VHA "can bring this action only as a facial challenge." Petition at 12. This assertion ignores both the terms of the VHA's Amended Complaint and the Court of Appeals' ruling on associational standing. The only case cited by the defendants, *Randall v. Lukhard*, 709 F.2d 257 (4th Cir. 1983), relevant holdings adopted on rehearing *en banc*, 729 F. 2d 966 (4th Cir.), cert. denied, 469 U.S. 872 (1984), was properly distinguished by the Fourth Circuit. App. at A-16, n.12. *Randall* involved a single historical act (denial of Medicaid eligibility), unlike the instant case which involves continuing federal law violations adversely affecting reimbursement to hospitals participating in the Medicaid system.

issues and rejected them. App. at A-12, 13, 14. Moreover, these issues were not raised in the petition as questions presented and are not properly before the Court. Rule 21.1(a), Rules of the United States Supreme Court.

D.

ABSTENTION IS WHOLLY INAPPROPRIATE AND INAPPLICABLE, GIVEN THE FACTS OF THIS CASE.

The defendants do not present any important or undecided federal abstention issue which merits review by this Court. The sole basis for defendants' abstention argument is that they have allegedly established a comprehensive regulatory framework which would be disrupted by federal court review. Petition at 14-15.

However, the Virginia Medicaid Program rules do not provide an opportunity for review of the VHA claims. As the Court of Appeals found, App. at A-12, n.9 and A-17, 18, the relief sought by the VHA is simply not available through the administrative process established by defendants.⁷

The defendants' reliance on the abstention doctrine of *Burford v. Sun Oil Company*, 319 U.S. 315 (1943) is misplaced. The *Burford* plaintiffs, through diversity jurisdiction, sought federal court review of a Texas Railroad Commission order which uniformly regulated oil and gas field drilling in

⁷ Cf. *Ohio Civil Rights Comm'n v. Dayton Christian Schools, Inc.*, 477 U.S. 619, 627 (1986) (cited by defendants) (finding abstention appropriate where a plaintiff would have a full and fair opportunity to litigate a constitutional claim).

Texas. The VHA's systemic challenge to defendants' failure in this federal question case to comply with applicable federal law in the development and implementation of the Virginia Medicaid Program is simply not analogous to the individualized state property law dispute at issue in *Burford*. Here, there is no risk of an inconsistent application of state law, as the law which controls the resolution of this matter is federal⁸ and the relief requested would benefit all providers.⁹ Cf. *Bath Memorial Hosp. v.*

⁸While state participation in the Medicaid Program is voluntary, once a state elects to participate, it must comply with applicable federal law and regulations. *Harris v. McRae*, 448 U.S. 297 (1980).

⁹Defendants' exhaustion claim relating to the use of the existing Appeals System, petition at 15, has nothing to do with abstention. Moreover, it is disingenuous. The VHA members' "failure to prosecute any appeals filed under the Appeal System" is a direct result of an agreement between the parties to the case. The Court of

Maine Health Care Finance Comm'n, 853 F.2d 1007 (1st Cir. 1988) (declining to follow Burford abstention in a challenge to the state hospital rate setting methodology).

Defendants' final argument relating to ripeness is not properly presented before this Court in defendants' petition. Rule 21.1(a), Rules of the United States Supreme Court. However, even if it were stated as a question presented to the Court, the Court of Appeals' finding that the case is ripe for review is consistent with this Court's decisions in *Abbott Laboratories v. Gardner*, 387 U.S. 136 (1967) and *Toilet Goods Association, Inc. v.*

Gardner, 387 U.S. 158 (1967). Based on the facts now present in the record, the Court of Appeals found nothing speculative about the VHA's claims. The actions challenged are essentially legal products of final agency action, and delay in reviewing these actions produces

Appeals below referred to defendants' claim during oral argument on this issue as "ungracious", and it remains so here.

significant hardship to VHA members.¹⁰
App. at A-16, 17.

VI.

CONCLUSION

The Court of Appeals and District Court below have properly construed the applicable precedents of this Court and correctly found that the VHA has an enforceable right under 42 U.S.C. § 1983 to assert its claims, that the prospective relief sought against state officials falls within the *Ex Parte Young* exception to Eleventh Amendment immunity, that the state officials cannot use the state statute of limitations as a shield for their continuing violations of federal law, and that the instant case presents a matter of federal concern appropriately considered in federal court. The defendants' petition does not offer any conflicting Court or circuit

¹⁰ Defendants' reliance on *Wilmac Corp. v. Bowen*, 811 F.2d 809 (3d Cir. 1987) is also misplaced. In *Wilmac*, the Third Circuit found the provider's claim to be premature because the disputed regulation in *Wilmac* did not compel or penalize any current conduct by the provider. *Id.* at 813. *Wilmac* incurred the injury only if it decided to construct an addition to its facility and if it decided to accept Medicaid patients there. *Id.* By contrast, VHA providers currently incur harm from defendants' failure to pay rates which comply with 42 U.S.C. § 1396a(a)(13)(A). Such injuries are neither speculative nor subject to full recovery through postponement of judicial review, due in part to the Eleventh Amendment bar from obtaining any prejudgment monetary benefit from the equitable relief sought. Moreover, such injuries cannot be avoided due to the legal obligations of a majority of VHA members to treat Medicaid recipients based on a hospital's past participation in the Hill-Burton Program. See 42 U.S.C. § 291 et seq. Additionally, all VHA members are now required to treat Medicaid recipients that come to the hospital in emergency conditions or active labor. See 42 U.S.C.A. § 1395dd (1986). Accordingly, the VHA members' participation in the Virginia Medicaid Program can hardly be described as "voluntary". Petition at 6, n.3.

court precedent, nor does it demonstrate any important question of federal law that merits resolution by this Court on interlocutory appeal.

WHEREFORE defendants' petition for a writ of certiorari should be denied.

Respectfully submitted,

THE VIRGINIA HOSPITAL ASSOCIATION

By _____
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APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF VIRGINIA

Richmond Division

**THE VIRGINIA HOSPITAL
ASSOCIATION,**

Plaintiff,
v.

CIVIL ACTION
NO. 86-0166-R

GERALD L. BALILES,
et al.,

Defendants.

**MEMORANDUM IN SUPPORT OF THE
COMMONWEALTH'S MOTION FOR STAY OF
FURTHER PROCEEDINGS**

The Commonwealth has moved this Court to stay further proceedings in this matter. The principal reasons for this motion are: (1) The Commonwealth is in the process of seeking a writ of certiorari from the United States Supreme

Court to review the affirmance by the United States Court of Appeals for the Fourth Circuit of this Court's rulings on eight jurisdictional issues; and (2) the fact that the Commonwealth's ongoing process of review of Medicaid reimbursement rates may well render this proceeding moot.

BACKGROUND

In 1986, the Virginia Hospital Association ("VHA") filed this action to challenge the provisions of the Commonwealth's State Plan for Medical Assistance relating to the reimbursement of hospitals for treatment of Medicaid patients. Since these provisions had been previously challenged and upheld by this Court, in Mary Washington Hospital v. Fisher, 635 F. Supp. 891 (E.D. Va.

1985), this Court dismissed the case on grounds of collateral estoppel. The Fourth Circuit reversed. Virginia Hospital Association v. Baliles, 830 F.2d 1308 (1987).

On remand, the Commonwealth moved for summary judgment on eight jurisdictional issues. This Court denied that motion, but stayed further proceedings on May 4, 1988 and on May 18, 1988 certified those issues for interlocutory appeal. The Fourth Circuit granted that appeal on July 27, 1988 and on February 22, 1989 affirmed this Court's ruling. It denied a rehearing on March 22, 1989 and denied a stay to the Commonwealth's pending application for a writ of certiorari on March 29, 1989.

I.

A STAY OF FURTHER PROCEEDINGS IS APPROPRIATE TO AVOID WASTING THE TIME AND RESOURCES OF THIS COURT AND OF THE PARTIES IN PROCEEDING WITH POTENTIALLY UNNECESSARY DISCOVERY AND TRIAL

The eight preliminary issues decided by this Court and the Fourth Circuit are all jurisdictional in nature. They include the right of a provider or its association to litigate against a Medicaid Program pursuant to 42 U.S.C. §1983, the standing of the VHA to bring this action, the bar of the Eleventh Amendment, the bar of the statute of limitations, the lack of ripeness of this case, the fact that this Court should have abstained, and the correct application of the doctrine of stare decisis.

For reasons previously briefed in this Court and in the Fourth Circuit and not repeated here in detail, it is clear that the issues raised by the Commonwealth are significant jurisdictional questions arising under both the Constitution and the Medicaid Act (Title XIX of the Social Security Act). They raise important points that need to be resolved with finality in order to guide the conduct of the Commonwealth and other states in this and other similar litigation in the federal court system.¹ The significance of this litigation is reinforced by the fact that

¹The Supreme Court has already granted a writ of certiorari on one of the issues herein - the right of a Medicaid provider to sue under §1983 - but the case was not decided on the merits. See, *Coos Bay Care Center v. Oregon*, 803 F.2d 1060 (9th Cir. 1986), cert granted, 107 S.Ct. 1970, vacated as moot, 108 S.Ct. 52 (1987).

27 states either signed or endorsed an amicus brief filed in the Fourth Circuit in support of the Commonwealth.

Moreover, if any one of these issues is heard and decided by the United States Supreme Court in favor of the Commonwealth, the result will be to end or substantially reduce the scope of this litigation in this Court. Should a stay not be granted, the parties must now prepare for an extended period of discovery and trial, along with possible future appeals.

In order to avoid such an expensive, time-consuming and potentially superfluous use of resources, this Court should grant this Motion. If the United States Supreme Court does grant a writ of certiorari, a continued stay will be essential. If it does not, since this

litigation has already been extended for a period of over three years, the modest amount of additional time that may expire in the interim will have little impact on the eventual outcome.

II.
IMPENDING REVISION OF THE COMMONWEALTH'S REIMBURSEMENT PROCESS MAY RENDER THIS LITIGATION MOOT, IN WHOLE OR IN PART

Although the Commonwealth has always had in place an ongoing process of review of Medicaid reimbursement, as a result of direction by the 1988 General Assembly, the Department of Medical Assistance Services has commissioned and now has in progress an independent study by a contract consultant to review the current system and recommend improvements and changes.

The consultant has been directed to

examine the hospital reimbursement system and its resultant reimbursement rates as a first priority. Accordingly, within the next few months, this major study with its recommendations will be delivered to the Commonwealth and will be made available to all Medicaid providers and to the public, including VHA. Public procedures will take place over the balance of 1989 with the result that the Department of Medical Assistance Services will, as directed by the General Assembly, make its recommendations to the 1990 session of the legislature for whatever revisions may appear appropriate.

While there are no guarantees to VHA concerning the recommendations that may be made or the action that may be taken, one thing is certain. Within the next

few months, it is entirely possible that this process will moot, in whole or in part, any controversy between the parties to this litigation. If this case proceeds precipitously to trial, the Court, if it found VHA's allegations to have any merit, could find itself ordering the Commonwealth to do that which it has already done or is currently doing.² Since VHA has maintained in both this Court and the Fourth Circuit that it does not seek retroactive relief - in fact it seeks only prospective relief - it would appear prudent for the Court to stay further proceedings until it is determined whether or not any ongoing

²If, in fact, this Court were to conclude that the current system required review and revision, such re-review would only serve to further delay the implementation of any potential changes.

controversy will remain after the Commonwealth's study is released and the General Assembly has acted on it.

CONCLUSION

WHEREFORE, if this matter is not stayed, the Court will of necessity be required to hear a complex and time-consuming suit. In the meantime, the Supreme Court may grant a writ of certiorari and reverse any one of the jurisdictional issues. In addition, intervening events may moot this case in whole or in part. As a result, the Commonwealth respectfully requests the Court to grant this Motion and to issue a stay of further proceedings herein.

Respectfully submitted,

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In the Supreme Court of the United States

OCTOBER TERM, 1988

GERALD L. BALILES, et al.

Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

Brief Amici Curiae of the States of
Alaska, Arizona, Colorado, Connecticut, Delaware,
Florida, Georgia, Hawaii, Idaho, Illinois, Indiana,
Iowa, Kansas, Kentucky, Louisiana, Michigan,
Minnesota, Mississippi, Missouri, Montana, Nebraska,
Nevada, New Hampshire, New Jersey, North Dakota,
Oklahoma, Oregon, Pennsylvania, Rhode Island,
South Carolina, South Dakota, Tennessee, Utah,
Vermont, Washington, West Virginia and Wyoming

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BEST AVAILABLE COPY

QUESTION PRESENTED

**Whether the Medicaid statutes give health care providers
(i.e., hospitals and nursing care homes) a private right of
action enforceable through 42 U.S.C. § 1983 (1982) to chal-
lenge state reimbursement decisions in federal court.**

INTEREST OF AMICI CURIAE

The State of Oregon et al. submit this brief as *amici curiae* in support of the petition for writ of certiorari filed by the Commonwealth of Virginia. Virginia seeks review of the decision of the United States Court of Appeals for the Fourth Circuit in *Virginia Hospital Association v. Baliles*, 868 F.2d 653 (4th Cir. 1989). In urging the Court to grant certiorari, the State of Oregon is joined by 36 additional states.¹ The *amici* states, individually and collectively, have a strong interest in the issues presented by the Commonwealth of Virginia in its petition. In particular, they have an overriding interest in the first question presented: whether health care service providers have a right enforceable through section 1983 to sue in federal court for a particular level of Medicaid reimbursement.

Medicaid is a voluntary, cooperative federal-state program that provides funds to reimburse certain costs of medical treatment for the needy. Each of the *amici* states participates in the Medicaid program, except Arizona. See footnote 1. As required by federal law, a participating state's Medicaid program must fund institutional medical care, including care in inpatient hospitals, nursing facilities, and intermediate care facilities (collectively referred to as "providers"). The amount of federal-state dollars directed to needy persons through private, for-profit providers is a major portion of the overall Medicaid program.

The *amici* states have a substantial financial stake in the outcome of this case and a significant legal interest in its

¹This brief of *amici curiae* is filed pursuant to Rule 36.4 of the Rules of the Supreme Court. The *amici* states are listed in Appendix A to this brief. Amicus State of Arizona does not participate in the Medicaid program directly. However, it participates in a cooperative state-federal program under a special grant that provides funds for indigent health care. Because of the similarities between this special grant program and the Medicaid program, Arizona has an interest in the issues presented in the petition for writ of certiorari.

resolution. The decision below holds that a health care provider may bring an action under section 1983 to challenge the provider reimbursement rate set by a state and approved by the federal government. Providers are thus free to attack, on a year-by-year and provider-by-provider basis, the "reasonableness" of each state's reimbursement rates. Every routine rate challenge may be made a federal case.

Many of the *amici* states already are caught up in the explosion of provider litigation based on alleged federal rights to specific levels of reimbursement. Indeed, some *amici* states are under siege by multiple lawsuits for different years, different classes of providers and inconsistent claims as to the rate allegedly guaranteed by federal law. Millions of state and federal dollars are potentially at stake in each lawsuit. Collectively, hundreds of millions of dollars are involved. The question of provider entitlement to bring these federal lawsuits needs resolution at a national level. The *amici* states therefore file this brief to urge the Court to grant the Commonwealth of Virginia's petition for writ of certiorari.

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SUMMARY OF ARGUMENT

Congressional intent, as revealed by the language and history of the 1980 amendments to the Medicaid statutes, refutes the lower court's conclusion that providers have a right to sue states over reimbursement rates under the aegis of section 1983. The amended version of the statute provides only that states must provide "assurances" to the Secretary of Health and Human Services that rates are reasonable and adequate. There is no language in the amended statute suggesting enforceable rights. The history of the amendments confirms Congress intended to decrease federal oversight of state rate-making. Layering judicial scrutiny on top of administrative review runs directly counter to that intent. Rather than reducing federal oversight of the state rate-making process and entrusting the states with primary responsibility for those rates, as Congress intended, the result below increases federal oversight and transfers primary rate-setting authority to the federal courts. That transfer of authority threatens to spill over to permit private rights of action pursuant to other statutory systems under the lower court's misapplication of the "enforceable rights" doctrine.

The lack of support for provider enforceable rights in the language and history of the statutes has caused those circuits that have found such a right to employ inconsistent and often contradictory analyses. The courts disagree about the applicability of this Court's cases to this issue. Some courts find providers to be "intended beneficiaries" of the Medicaid statutes; others reject that conclusion. The circuits have not found a coherent approach consistent with this Court's jurisprudence of enforceable rights under section 1983. Because of the uncertainty among lower courts in their analyses and the importance of the issue, this case merits this Court's review.

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ARGUMENT

I. This case involves issues of substantial importance.

This case presents the same issue on which this Court granted certiorari in *Coos Bay Care Center v. Oregon*, 803 F.2d 1060 (9th Cir. 1986), cert. granted, 481 U.S. 1036, judgment vacated and remanded on issue of mootness, ___ U.S. ___, 108 S.Ct. 52 (1987) (*Coos Bay*). Did Congress intend to permit providers of health care services under 42 U.S.C. § 1396a(a)(13)(A) (1986) to bring suit against the states under 42 U.S.C. § 1983 (1982) when it amended the Medicaid statutes in 1980? The issue is no less important today than it was in 1987 when a majority of the states, several organizations representing local governments, and the United States Solicitor General all joined Oregon in requesting this Court to reverse the decision of the Ninth Circuit Court of Appeals allowing providers to sue. Indeed, the rapid growth of litigation in the area and the enormous amounts of money at stake bear stark witness to the Court's prudence in agreeing to hear that case.

The number of challenges to state reimbursement systems by providers of inpatient hospital and long-term care services to Medicaid recipients has been substantial in recent years.² Each of these challenges has the potential to involve very large amounts of money drawn from both state and federal treasuries.³ Because the total number of state and federal dollars paid annually through medical assistance programs is truly staggering, the burgeoning number of cases has the potential to subject federal and state governments to lia-

bility running easily into the hundreds of millions of dollars.⁴

II. Neither the history nor the language of section 1396 supports finding that providers have rights enforceable through section 1983.

In *Maine v. Thiboutot*, 448 U.S. 1 (1980), this Court held that the phrase "and laws" in 42 U.S.C. § 1983 (1982)⁵ must be read literally, so as to create under that section a private cause of action against state officials for violations of rights conferred by federal statutes. One year after *Thiboutot*, the Court "recognized two exceptions to the application of § 1983 to statutory violations." *Middlesex County Sewerage Auth. v. Nat'l Sea Clammers Ass'n*, 453 U.S. 1, 19 (1981) (*Sea Clammers*), citing *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981) (*Pennhurst*). The Court held that a section 1983 action will not lie where (1) Congress has foreclosed private enforcement of the federal statute in the statute itself, or (2) the statute does not create "enforceable rights" under section 1983. *Sea Clammers*, 453 U.S. at 19; *Pennhurst*, 451 U.S. at 28; see also *Wright v. City of Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418, 423-24 (1987)

⁴ As the United States Solicitor General noted in his brief in support of the State of Oregon in *Coos Bay*, the federal contribution to the Medicaid program for medical assistance totalled \$23.4 billion in 1986. Brief For The United States As Amicus Curiae Supporting Petitioners, at 2, citing HEALTH CARE FINANCING ADMIN., DEP'T OF HEALTH AND HUMAN SERVICES, MEDICAID FINANCIAL REPORT: FISCAL YEAR 1986. Federal funds comprised at least 50 and in some cases more than 70 percent of each state's medical assistance program in 1986. 49 Fed. Reg. 46,957 (1984). The average figure was approximately 58 percent. Thus, treating 1986 as a representative year, and including the states' contribution, the total medical assistance budget is over \$40 billion per year.

⁵ 42 U.S.C. § 1983 (1982) provides, in pertinent part:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. . . .

² See Appendix B for a list of some currently pending section 1983 challenges to Medicaid reimbursement rates.

³ For example, *Volk, et al. v. Oregon, et al.*, cited in Appendix B, although involving only one year's reimbursement schedule and involving the nursing home industry but not hospitals, has over \$5 million at stake, more than \$3 million of which is federal money. The several Pennsylvania cases may entail liability of \$80 million.

(*Roanoke*). This case falls within the second exception: Congress did not intend to afford enforceable rights to providers of health care services when it amended the Medicaid statutes in 1980.

In *Pennhurst* the Court concluded that whether Congress intended to create rights enforceable under the aegis of section 1983, when it does not expressly provide for such actions in a given enactment, must be determined from the language and history of the act. In this case, the history, which demonstrates that Congress intended to increase state autonomy and decrease federal oversight in the Medicaid reimbursement rate-setting process, illuminates the language, which is not the right- or duty-creating language a court must find to support a claim of rights enforceable under section 1983.

A. The history of section 1396 supports a result directly contrary to that reached in the lower court.

By the earlier reference to the increasing numbers of suits challenging state reimbursement rates, *amici* do not merely suggest the federal courts will be met with a flood of litigation, although those waters are unquestionably rising. The point, rather, is that year-by-year, provider-by-provider litigation over each aspect of each state's plan is becoming the rule, a reality manifestly inconsistent with Congress' unmistakable intent to reduce rather than increase federal oversight of the rate-making process. That intent is conspicuous in the legislative history surrounding the enactment of the 1980 amendments to the Medicaid statutes.

In 1980, in response to the "inherently inflationary" nature of the former "reasonable cost" standard, Congress enacted the Boren Amendment to the Medicaid statutes.⁶ S.

⁶ Now embodied in 42 U.S.C. § 1396a(a)(13)(A) (1986).

Rep. 96-471, 96th Cong., 1st Sess. 28-29.⁷ The amendment "represented a significant change in the federal [reimbursement] standard," offering the states an opportunity to effect "more stringent cost containment" while freeing them from excessive "federal oversight of [their] reimbursement methodologies." *Wisconsin Hospital Ass'n v. Reivitz*, 733 F.2d 1226, 1228 (7th Cir. 1984). Congress chose to "give[] the States flexibility and discretion . . . to formulate their own methods and standards of payment." S. Rep. 96-471, at 28. By the same token, Congress intended "to reduce federal oversight of state reimbursement." *Mississippi Hosp. Ass'n., Inc. v. Heckler*, 701 F.2d 511, 521 (5th Cir. 1983). While pointing out that the Secretary would continue to insist on "assurances . . . that the payment rates . . . are reasonable and adequate," Congress "expect[ed] that the Secretary will keep regulatory and other requirements to that minimum necessary to assure proper accountability, and not overburden the States and facilities with marginal but massive paperwork requirements." S. Rep. 96-471, at 29. It is distinctly ironic that a Congressional effort to reduce cumbersome federal oversight of state programs and to contain Medicaid costs has become the impetus for a mounting tide of litigation and potential liability.

In the opinion below, the Fourth Circuit Court of Appeals acknowledged that, in *Pennhurst*, this Court left no doubt that Congressional intent is the "touchstone" of the enforceable rights inquiry. The lower court's discussion of that intent,

⁷ There was no Senate or House report accompanying the Boren Amendment in 1980. Floor discussion of the Amendment, however, makes clear that it was drawn from a bill reported the previous year by the Senate Finance Committee. See 126 Cong. Rec. 17,885-86 (1980). The Boren Amendment does not differ materially from the provision contained in the 1979 bill. See S. Rep. 96-471, *supra*, at 157-58. The text reported here is from the Senate report that accompanied the 1979 bill.

however, is largely limited to statements that merely reiterate the statutory references to "reasonable and adequate" rates. See 868 F.2d at 658-59. The court acknowledged that the purpose behind the Omnibus Budget Reconciliation Act (OBRA), of which the Boren Amendment was a part, was to reduce the federal budget. The court ignored, however, the parallel and equally important intent of the Boren Amendment to reduce federal oversight of state programs. Refusal to acknowledge this central goal of the Boren Amendment spared the court the unenviable task of reconciling the inevitably more intrusive effects of piecemeal litigation with Congress' indisputable intent to increase state autonomy in rate-setting.⁸

Based on its conclusion that Congress "intended no close scrutiny by the Secretary [of Health and Human Services]" of assurances by the states, the court below reasoned that the only way to effectuate the "guarantee" of reasonable and adequate rates is to allow providers to bring suit. 868 F.2d at 659. This deduction is based on a faulty reading of Congressional intent and an unjustified denigration of the role of the Secretary.

The lower court correctly noted that Congress intended that state assurances would be considered satisfactory in the absence of a formal finding to the contrary by the Secretary. However, the court ignored the equally plain Congressional insistence on "proper accountability" to ensure that payment rates are, in fact, reasonable and adequate. See S. Rep. 96-471, at 29. The court's suggestion that Congress intended the Secretary to become a mere rubber stamp for

⁸ Rather than having to defend its rates once, before a federal administrative agency, the states will now be forced to defend piecemeal as each disgruntled facility or band of facilities looks for the most sympathetic forum. For example, the Commonwealth of Pennsylvania is currently embroiled in six separate challenges. See Appendix B.

whatever rates the states might conjure up is inconsistent not only with these expressions of Congressional intent, but also with the Secretary's view reflected in the regulations issued to implement the Boren Amendment,⁹ and the Secretary's actions in reviewing state plans. See, e.g., *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291 (8th Cir. 1985) (discussing Secretary's disapproval of part of Nebraska's plan for 1983-84).

Congress intended to decrease, not increase, federal oversight of the rate-setting process. To that end Congress cut back federal administrative supervision to a level it deemed adequate to ensure proper accountability. The court of appeals has undone Congress' balance by layering judicial scrutiny onto administrative oversight. Supervision by litigation will almost inevitably entail greater delay and disruption in the administration of state Medicaid plans than would result from oversight by the Secretary even under the more demanding pre-Boren Amendment requirements. That result is manifestly inconsistent with Congress' intent and therefore erroneous.

B. The language of section 1396 is not rights-creating language.

The act under consideration in *Pennhurst* referred to "rights" accorded to the intended beneficiaries of the act and

⁹ See, e.g., Preamble to Interim Final Rule, Medicaid Program; Payment for Long-Term Care Facility Services and Inpatient Hospital Services, 46 Fed. Reg. 47,964, 47,966 (1981). The regulations, as revised to meet the requirements of the 1980 amendments, require states to submit assurances at least annually and whenever they propose significantly to revise methods for determining payment rates. When amending plans or submitting new ones, states must submit related information on short term effects and, to the extent feasible, long-term effects, on availability of care, type of care furnished, extent of provider participation and the degree to which costs are covered in hospitals serving a disproportionate number of low income patients. The Health Care Financing Administration "will review the information a State submits with respect to these items to determine whether it is reasonable to justify acceptance of the State's assurances." *Ibid.*

"obligations" on the part of the states. Despite that language, this Court concluded Congress had not intended to create *enforceable* rights against the states. Rather, the Court determined, the language in question was merely precatory, a "nudge" in Congress' preferred direction. 451 U.S. at 19.

The language of section 1396a(a)(13)(A) is far less likely to be employed by a Congress desirous of creating enforceable rights than is the language at issue in *Pennhurst*. Section 1396a(a)(13)(A) does not contain a specific grant of a private right of action. Nor does it read like a statute designed to "dictate specifically what the relevant government officials may and may not do." *Edwards v. District of Columbia*, 821 F.2d 651, 656 (D.C. Cir. 1987). Far from containing "right- or duty-creating language," *Cannon v. University of Chicago*, 441 U.S. 677, 690 n. 13 (1979), section 1396a(a)(13)(A) permits participating states to devise reimbursement rates "which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities . . ." The statute also provides that these rates are to be set "in accordance with methods and standards developed by the State." By its terms, therefore, section 1396a(a)(13)(A) vests rate-making discretion in the state, subject to the condition that it makes "assurances satisfactory to the Secretary." As the *Pennhurst* Court noted in the context of the statute at issue in that case, "[i]t is at least an open question whether an individual's interest in having a State provide . . . 'assurances' [to the Secretary] is a 'right secured' by the laws of the United States within the meaning of § 1983." 451 U.S. at 28. Indeed, if the statutory requirement of assurances by the states confers any right on providers, it is only the right to have those assurances provided to the Secretary. The provision of the assurances then engages the machinery of the Secretary's review. The Secretary examines

the assurances, the rates and the supporting data to determine whether the rates meet the statutory standard. The providers' "right," if any, is the right to have the Secretary perform his or her duty and conduct the required review to ensure proper accountability, not the "right" to substitute themselves and the courts for the state, under the scrutiny of the Secretary, as rate-maker.

Thus, in *Pennhurst*, this Court did not find enforceable rights despite language of right and obligation. Here, by contrast, the court of appeals found enforceable rights despite the lack of right- or duty-creating language and in the face of the much more limited language of "assurances," language this Court has previously questioned as the basis of "enforceable rights."

The lower court acknowledged that the statute at issue in this case, like the statute in *Pennhurst*, was enacted under the spending power of Article I, section 8, clause 1, of the United States Constitution. 868 F.2d at 657, n. 3. *Pennhurst*'s insistence on clear legislative direction in spending power cases stemmed from the Court's concern that states be informed of their obligations in unambiguous terms when they enter into a voluntary, federally supported program.

[L]egislation enacted pursuant to the spending power is much in the nature of a contract . . . The legitimacy of Congress' power to legislate under the spending power . . . rests on whether the State voluntarily and knowingly accepts the terms of the "contract" . . . There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it.

451 U.S. at 17 (citations omitted). The lower court believed this concern is "allay[ed]" in this case because the states undoubtedly knew they were agreeing to pay reasonable and adequate rates when they elected to participate in the pro-

gram. 868 F.2d at 659. It is one thing to say the states knowingly bound themselves to pay reasonable and adequate rates under the supervision and control of the Secretary. However, it is quite another to say they knowingly agreed to defend expensive, time-consuming and disruptive litigation in state and federal courts brought by each disgruntled provider over every aspect of and change in their programs. To make a simple analogy, even a consumer who felt she had no real choice but to enter into a particular contract is entitled to know it has an attorney fees provision in it.

Providers, like the states, are voluntary participants in the Medicaid program. See 42 C.F.R. § 447.204 (1985); *Minnesota Assoc. of Health Care Facilities v. MAHCF*, 742 F.2d 442, 446 (8th Cir. 1984), cert. denied, 469 U.S. 1215 (1985) (providers are free to decline to participate in the Medicaid program if they are dissatisfied with a state's rates). Thus providers have the ability to opt out of the Medicaid program any time a state's rates are such that they believe it is not economically desirable to participate. Even so, as a condition to state participation, the Secretary requires each state to have in place an administrative appeals process through which providers may challenge reimbursement rates. 42 C.F.R. § 447.253(c) (1985). However, the Secretary, whose interpretation is entitled to "some deference," *Roanoke*, 479 U.S. 418, 427, expressly has rejected the call for private rights of action in the regulations adopted to implement the Boren Amendment on the ground that the statutes contained neither mandate nor authority to provide judicial recourse for dissatisfied providers. 48 Fed. Reg. 56,052 (1983); see also Preamble to Final Rule, Medicaid Program; Payment for Long-Term Care Facilities and Inpatient Hospital Services, 48 Fed. Reg. 56,046 at 56,050 (1983).

III. The results in the circuits are inconsistent.

Because of the proliferation of section 1983 actions against the states based on statutes that do not expressly provide for private rights of action, the states have a significant stake in the development of the law of enforceable rights under that section. Although the cases in the various federal circuit courts of appeal cannot fairly be described as in direct conflict, the courts have not found a consistent analysis. For example, the Ninth Circuit concluded in *Coos Bay Care Center v. Oregon* that it was "not necessary to engage in a *Pennhurst* analysis." 803 F.2d at 1062. The lower court in this case, by contrast, concluded that a *Pennhurst* analysis was indeed required. 868 F.2d at 657 n. 3.

The Ninth and Tenth Circuits have concluded that providers have standing under section 1396a(a)(13)(A) based on their view that providers are intended beneficiaries of the Medicaid statutes with interests "parallel" to those of patients. See *Colorado Health Care Ass'n v. Colorado Dept. of Social Services*, 842 F.2d 1158, 1164, n. 5 (10th Cir. 1988); *Coos Bay*, 803 F.2d at 1063.¹⁰ At least two other circuits have rejected the conclusion that providers are intended beneficiaries. *Green v. Cashman*, 605 F.2d 945 (6th Cir. 1979), and *Case v. Weinberger*, 523 F.2d 602 (2d Cir. 1975). In *Green*, the court stated:

¹⁰ Whatever the courts may have meant by describing those interests as "parallel," it strains credulity to suggest they are the same. A patient's interest is in having the maximum number of Medicaid dollars spent on direct patient care in the form of food, additional and better-trained staff, better equipment and other items that increase patient comfort and well-being. The interest of the average for-profit provider is in returning the maximum number of Medicaid dollars to shareholders or owners in the form of profit. While both may seek more money from the state, merely providing more money does not guarantee the patients' interests will benefit. The "parallel interest" approach is tantamount to asserting that landlords are intended beneficiaries of government rent subsidies.

We do not find in the statute authorizing Medicare and Medicaid any legislative intention to provide financial assistance to providers of care for their own benefit. Rather, the statute is designed to aid the patients and clients of such facilities.

605 F.2d at 946. *Amici* do not agree that "interest" analysis is appropriate for determining enforceable rights under section 1983.¹¹ Even so, those courts embarking on that approach are at best in unsettled waters in concluding that section 1396a(a)(13)(A) provides standing to providers, as the disagreement among the circuit courts of appeal demonstrates.

Thus, the circuits do not agree on the applicability of this Court's opinions and, assuming that the identity of the intended beneficiaries of the Medicaid statutes is a relevant inquiry, they do not agree whether providers fall within that class. In light of the enormous amounts of money at stake in these cases, the importance to both the state and federal governments of a clear application of the law of enforceable rights under section 1983, and the ever-increasing amount of litigation by providers, this Court should determine whether providers have enforceable rights under section 1396a(a)(13)(A).

CONCLUSION

For the reasons stated above, this Court should grant the Commonwealth of Virginia's petition for writ of certiorari.

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¹¹ The Ninth Circuit "special beneficiary" test is "borrowed" from the implied right of action test of *Cort v. Ash* 422 U.S. 66 (1975). See 803 F.2d at 1062-63. The *Cort* test is designed to determine whether Congress intended to imply a right of action in a substantive statute itself, without reference to section 1983. *Thiboutot, Pennhurst, Sea Clammers, et al.*, by contrast, seek to know if Congress intended to permit private enforcement via section 1983. The inquiries are distinct. See, *Thiboutot*, 448 U.S. at 6. The issue under *Cort* is who can enforce a right provided by statute. The issue under section 1983 is whether there is any secured right to enforce.

Indeed, this approach is demonstrably inconsistent with *Pennhurst*. No one denied that the "bill of rights" provision of the act at issue in *Pennhurst* was enacted for the benefit of the class of institutionalized persons with mental retardation that included the plaintiffs in that case. That, however, was not sufficient to support the conclusion Congress intended to grant those intended beneficiaries rights enforceable under section 1983.

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APPENDIX B PENDING LITIGATION

COLORADO

Amisub (PSL), Inc. v. State of Colorado, Department of Social Services, No. 88-2482—United States Court of Appeals for the Tenth Circuit

DELAWARE

The Medical Center of Delaware, Inc. v. Eichler, No. 89-MY-9-1-CA—(petition for removal to United States District Court pending)

GEORGIA

Health Facility Investments, Inc. dba Ansley Pavilion v. Johnson, No. 1:89CF844JOF—United States District Court, Northern District of Georgia

HAWAII

Beverly Manor, Inc. v. Rubin, No. 85-0052—United States District Court, District of Hawaii

IDAHO

Idaho Health Care Association, et al. v. Bowen, No. 88-1425—United States District Court, District of Idaho

Jeff D., et al. v. Andrus, No. 87-3586—United States Court of Appeals for the Ninth Circuit

Pope v. Donovan, No. 67738—District Court of the State of Idaho

ILLINOIS

Chicago Osteopathic Medical Center, et al. v. Suter, No. 88C 1174—United States District Court, Northern District of Illinois

Illinois Health Care Association, et al. v. Suter, No. 89C
849—United States District Court, Northern District
of Illinois

MICHIGAN

Health Care Association of Michigan, et al. v. Department of Social Services, et al., No. 89-50063
CA—United States District Court, Western District
of Michigan

MINNESOTA

REM-Bemidji, Inc., et al. v. Sandra S. Gardebring, Commissioner of the Minnesota Department of Human Services, et al., No. 4-88-Civil-562—United States District Court, District of Minnesota; dismissed without prejudice December 2, 1988, to permit completion of administrative challenge

MISSISSIPPI

Mississippi Health Care Association v. J. Clinton Smith, No. JA 6-0765(B)—United States District Court, Southern District of Mississippi, Jackson Div. (consolidated with case below)

Independent Nursing Home Association v. J. Clinton Smith, No. JA 6-0731 (W)—(same court as above)

MISSOURI

A.G.I.-Bluff Manor, Inc. v. Michael Reagen, Director, Missouri Department of Social Services, et al., No. 85-4015-CV-CO5—United States District Court, District of Missouri

NEVADA

Hillhaven, Inc., et al. v. State of Nevada Department of Human Resources, et al., No. CV 88-6222—District Court of the State of Nevada, Washoe County

NORTH DAKOTA

North Dakota Hospital Association, et al. v. George A. Sinner, et al., Civ. No. A1-87-126—United States District Court, Southwestern District of North Dakota

OHIO

The Ohio Academy of Nursing Homes, Inc. v. Barry, et al., (88AP-826)—Court of Appeals of the State of Ohio (opinion June 22, 1989, certification to Ohio Supreme Court pending).

OREGON

Oregon Association of Hospitals v. Department of Human Resources, (CF 88-225-DA)—United States District Court, District of Oregon —

Volk, et al. v. State, et al., No. A50092—Oregon Court of Appeals

Francisco, et al. v. Department of Human Resources, et al., No. 89-6244—United States District Court, District of Oregon

PENNSYLVANIA

West Virginia University Hospitals, Inc. v. Casey, 701 F.Supp. 496 (1988) under advisement on appeal to the United States Court of Appeals for the Third Circuit

Temple University v. White, et al., Civ. No. 88-6646—Eastern District of Pennsylvania

Albert Einstein Medical Center, et al. v. White, et al., Civ. No. 88-8831—same as above

Frankford Hospital v. Department of Public Welfare, et al., Civ. No. 88-8927—same court

Hahnemann University Hospital, et al. v. Department of Public Welfare, et al., Civ. No. 88-9132—same court

Hospital Association of Pennsylvania, et al. v. White, et al., Civ. No. 88-9849—same court

SOUTH CAROLINA

ANCO, Inc., et al. v. State Health and Human Services Finance Commission, et al., No. _____—on appeal to South Carolina Superior Court

WASHINGTON

Folden, et al. v. DSHS, No. C87-802TB—United States District Court, Western District of Washington

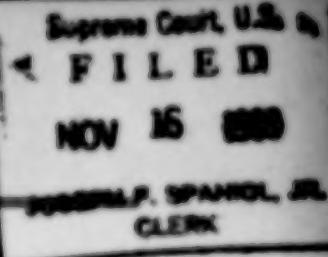
Multicare Medical Center, et al. v. State of Washington, et al., No. C88-421Z—same court

WISCONSIN

Beverly California Corporation v. Wisconsin Department of Health & Social Services, et al., No. 89-CV-2689—Dane County Circuit Court

St. Michael Hospital of Franciscan Sisters of Milwaukee, Inc. v. Thompson, et al., No. 89-C-620C—United States District Court, Western District of Wisconsin

No. 88-2043



In The

Supreme Court of the United States

October Term, 1989

GERALD L. BALILES, et al.,

Petitioners.

v.

THE VIRGINIA HOSPITAL ASSOCIATION,

Respondent.

On Writ Of Certiorari To The
United States Court Of Appeals
For The Fourth Circuit

JOINT APPENDIX

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Petition For Certiorari Filed June 15, 1989
Certiorari Granted October 2, 1989

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RELEVANT DOCKET ENTRIES

March 19, 1986 - Complaint filed

September 22, 1986 - Defendants' Motion for Summary Judgment Granted - Complaint Dismissed

October 13, 1987 - Reversed by Fourth Circuit Court of Appeals Opinion at 830 F.2d 1308

February 1, 1988 - Amended Complaint Filed

February 11, 1988 - Defendants' Motion for Summary Judgment Filed

March 25, 1988 - Motion for Summary Judgment Denied

May 4, 1988 - Order Granting Defendants' Motion for Stay of Proceedings

May 18, 1988 - Order Certifying Eight Jurisdictional Issues for Interlocutory Appeal - Memorandum Opinion (Reprinted in Appendix D to Petition for Certiorari)

May 31, 1988 - Defendants' Petition for Permission to Appeal Filed in Court of Appeals

July 27, 1988 - Court of Appeals Granted Permission to Appeal

IN THE UNITED STATES DISTRICT
FOR THE EASTERN DISTRICT OF VIRGINIA
RICHMOND DIVISION

THE VIRGINIA HOSPITAL ASSOCIATION,
A Virginia Non-Stock Corporation,
On Behalf Of Its Member Hospitals
And all Others Similarly Situated,

Plaintiff,

v.

Civil Action No.: 86-0166-R

GERALD L. BALILES,
Governor of the
Commonwealth of Virginia,

EVA S. TEIG,
Secretary of Human Resources
of the Commonwealth of Virginia,

RAY T. SORRELL,
Director of Medical
Assistance Services,

MS. BETTE O. KANTER
Member, State Board of
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MR. JOSEPH M. TEEFY
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and

MR. JOHN N. SIMPSON
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Defendants.

AMENDED COMPLAINT

I. PRELIMINARY STATEMENT

A. *Introduction*

1. This action arises under the federal social security laws and the United States Constitution. The federal statutory claims arise under Title XIX of the Social Security Act, 42 U.S.C. § 1396, *et seq.* (hereinafter referred to as "Medicaid Act"). The constitutional claims arise under the Supremacy Clause, Article 6, Section 2 and the Due Process Clause of the Fourteenth Amendment. The plaintiff herein seeks declaratory and injunctive relief from the application of the Virginia State Plan under Title XIX of

the Social Security Act, Attachment 4.19-A, "Methods and Standards for Establishing Payment Rates - In-patient Care" (hereinafter the "Medicaid Payment Program") and the "Final Regulations for Hospital Appeals of Reimbursement Rates" (hereinafter the "Appeals Regulations"), as amended, because the Virginia State Plan directly conflicts with the Medicaid Act's conditions for participation by states in Medicaid and denies hospitals due process of law in the establishment, payment and appeal of Medicaid reimbursement rates, in that said rates are not reasonable and adequate to meet the economically and efficiently incurred cost of providing care to Medicaid patients in hospitals and do not assure access to inpatient care, all as is required under the Medicaid Act and as is more fully set forth below.

B. Jurisdiction

2. This case arises under the Constitution and laws of the United States, including, but without limitation thereof, 42 U.S.C. § 1983 and 28 U.S.C. §§ 2201 *et seq.* Jurisdiction over this case is conferred upon this Court by 28 U.S.C. § 1331 and 28 U.S.C. § 1343 which provide for jurisdiction over federal questions and suits arising under 42 U.S.C. § 1983, respectively. The amount in controversy exceeds Ten Thousand Dollars (\$10,000.00), exclusive of interest and costs.

C. Parties

3. The Virginia Hospital Association (hereinafter "VHA") is a Virginia non-stock, not-for-profit corporation duly incorporated under the laws of the Commonwealth of Virginia for the purpose of developing and improving the hospital industry in Virginia. Its members include

both public and private hospitals operating in Virginia. The private hospitals are operated on both non-profit and profit bases. The member hospitals of the Virginia Hospital Association constitute the vast majority, some 90%, of all hospitals which participate in and receive payments under the Virginia Medicaid Payment Program. The VHA has the authority and the duty as a trade association to represent the financial interests of its members in obtaining reasonable and adequate payment for treatment of Medicaid beneficiaries. The issues of fact and law involved in this action are common to all Virginia Medicaid hospitals, joinder of all such hospitals is impracticable, and the VHA can adequately represent such hospitals on these common claims without requiring the participation of individual hospitals.

4. The Defendant Gerald L. Baliles is the Governor of the Commonwealth of Virginia and is charged with approving all amendments to the Virginia State Plan for Medical Assistance (hereinafter referred to as the "State Plan"). His predecessor did approve the submission of the Medicaid Payment Program as an amendment to the State Plan, and he has continued such approval, including approval, either directly, or indirectly of the Appeal Regulations as an amendment to Attachment 4.19-A and the State Plan. The Governor is named in his official capacity.

5. The Defendant Eva S. Teig is Secretary of Human Resources of the Commonwealth of Virginia and is charged with directing the actions of the Director of Medical Assistance Services. The Secretary's predecessor supervised the adoption of the Medicaid Payment Program and approved it as an amendment to the State Plan.

She has continued such supervision and approval, either directly or indirectly including approval of the Appeal Regulations as an amendment to Attachment 4.19-A and the State Plan. The Secretary is named in her official capacity.

6. The Defendant Ray T. Sorrell is the Director of Medical Assistance Services of the Commonwealth of Virginia. He is Secretary of the State Board of Medical Assistance Services and is charged with the direction of the Department of Medical Assistance Services (hereinafter "DMAS"). In such capacity, he is primarily responsible for the drafting and promulgation of the State Plan and any amendments thereto. His and DMAS's predecessors promulgated the Medicaid Payment Program as an amendment to the State Plan. He has promulgated the Appeal Regulations as an amendment to Attachment 4.19-A and the State Plan and has continued the Medicaid Payment Program's operation. Mr. Sorrell is also charged with the duty to administer the State Plan and to receive and expend federal funds thereof in accordance with applicable federal and state laws and regulations. The Director is named in his official capacity.

7. The Defendants Ms. Bette O. Kanter, Mr. Joseph M. Teefy, Mr. R. Michael Berryman, Ford Tucker Johnson, Sr., D.D.S., A. Epes Harris, Jr., M.D., Ms. Ruth Hanft, Patricia E. Sloan, R.N., Ed.D., Mr. Jordan H. Goldman, Mr. Robert B. Lambeth, Jr. Ms. Elsa A. Porter, and Mr. John N. Simpson, are members of the State Board of Medical Assistance Services (hereinafter referred to as the "Board"). The Board, subject to the approval of the Governor is authorized to prepare, amend and submit to the Secretary of the United States Department of Health and

Human Services the State Plan pursuant to Title XIX of the United States Social Security Act, and any amendments thereto. Pursuant to such authority, the Board's predecessor promulgated and adopted the Medicaid Payment Program, and the Board has continued that Program's operation. The Board has also promulgated and adopted the Appeal Regulations as an amendment to Attachment 4.19-A and the State Plan.

II. STATEMENT OF THE CLAIM

8. The Medicaid Act provides basic protection against costs of hospital and other health care services to certain indigent persons through payments by the federal government to states which elect to participate in Medicaid. As a condition of participation, each state must submit and receive approval on their state plans for medical assistance from the Secretary of Health and Human Services.

9. Pursuant to the Medicaid Act, 42 U.S.C. § 1396a(a)(13), a state plan for medical assistance must provide:

"(A) for payment . . . of the hospital . . . services provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to in-patient hospital services of adequate quality. . . ."

10. Pursuant to the Medicaid Act, the Secretary of the Department of Health and Human Services promulgated regulations regarding state plans which provide as follows:

"Subpart C - Payment for Inpatient Hospital and Long-Term Care Facility Services.

§ 447.250. Basis and purpose.

This subpart implements section 1902(a)(13)(A) of the Act, which requires that the State plan provide for payment for hospital and long-term care facility services through the use of rates that the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with State and Federal laws, regulations, and quality and safety standards.

* * *

§ 447.252 State plan requirements.

(a) The plan must provide that the requirements of this subpart are met.

(b) The plan must specify comprehensively the methods and standards used by the agency to set payment rates in a manner consistent with 45 CFR 201.2.

(c) If the agency chooses to apply the cost limits established under Medicare (see § 413.30 of this chapter) on an individual provider basis, the plan must specify this requirement.

* * *

§ 447.253 Other requirements.

(a) *State assurances.* In order to receive HCFA approval of a State plan change in payment methods and standards, the Medicaid agency must make assurances satisfactory to HCFA that the requirements set forth in paragraphs (b) through (g) of this section are being met, must submit the related information required by § 447.255 of this subpart, and must comply with all other requirements of this subpart.

(b) *Findings.* Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:

(1) *Payment rates.* (i) The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

(ii) With respect to inpatient hospitals services -

(A) The methods and standards used to determine payment rates take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs;

(B) If a State elects in its State plan to cover inappropriate level of care services . . . ,

the methods and standards used to determine payment rates must specify that the payments for this type of care must be made at rates lower than those for inpatient hospital level of care services, reflecting the level of care actually received, in a manner consistent with section 1861(v)(1)(G); and

(C) The payment rates are adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality.

(2) *Upper payment limits.* The agency's proposed payment rate will not exceed the upper payment limits as specified in § 447.272.

(c) *Provider appeals.* The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

(d) *Uniform cost reporting.* The Medicaid agency must provide for the filing of uniform cost reports by each participating provider.

(e) *Audit requirements.* The Medicaid agency must provide for periodic audits of the financial and statistical records of participating providers.

(f) *Public notice.* The Medicaid agency must provide that it has complied with the public notice requirements in § 447.205 of this part when it is proposing significant changes to its methods or standards for setting payment rates for inpatient hospital or LTC facility services.

(g) *Rates paid.* The Medicaid agency must pay for inpatient hospital and long terms care services using rates determined in accordance with methods and standards specified in an approved State plan."

As adopted, 46 F.R. 47964 (Sept. 30, 1981), and corrected at 46 F.R. 54743 (Nov. 4, 1981), and amended at 47 F.R. 31518 (July 20, 1982), 48 F.R. 56046 (Dec. 19, 1983, effective Jan. 18, 1984), and at 52 F.R. 28141 (July 28, 1987).

11. In 1982, Virginia sought and received approval of an amendment to its State Plan to change the method by which hospitals were to be reimbursed for providing care to Medicaid patients. The effect of the amendment was to change Virginia from a retrospective reimbursement system to a prospective payment system. The amendment became the Medicaid Payment Program, Attachment 4.19-A of the State Plan. Thereafter, Attachment 4.19-A was amended to include the Appeal Regulations which amendment was approved by Marilyn Koch, Acting Regional Administrator, Health Care Financing Administration, Department of Health and Human Services, on March 3, 1986. (Attachment 4.19-A, as amended, is attached hereto as Exhibit 1.)

12. The Medicaid Payment Program went into effect on July 1, 1982 and at such time it did not comply with the requirements of the Medicaid Act despite the assurances and findings of the Commonwealth of Virginia and the approval of the Secretary of Health and Human Services. The assurances and findings provided by the Commonwealth were inaccurate, a fact which was known or reasonably should have been known to the predecessors of these defendants.

13. This failure is now known to the Defendants, as is the fact that the reimbursement rates established pursuant to the Amendment continue to fail to meet the requirements of the Medicaid Act and regulations promulgated thereunder. No action sufficient to correct its deficiencies has yet been taken.

14. The Virginia Medicaid Payment Program is the methodology by which a prospective payment rate will be set for hospitals providing care to Virginia Medicaid patients. In essence, Virginia's prospective payment system places hospitals into various "peer groups" based upon size and location. There are three rural peer groups and four urban peer groups based upon facility size. For each, a median cost of care for a Medicaid patient day was calculated using Medicaid cost reports filed by hospitals in calendar year 1981. In addition to these peer groupings, further adjustments were made for the urban peer groups based upon wage variations between metropolitan areas. The differentials for wages were based upon labor costs in the Standard Metropolitan Statistical Areas (hereinafter "SMSA") as developed by the federal government, Office of Management and Budget. Each peer group's median cost per day thus identified was then inflated using a consumer price index of general application, adjusted to exclude capital costs (hereinafter the "Va. CPI"), to arrive at a median cost of care as of July 1, 1982. These medians were then used to set quarterly ceilings on the rate of per diem reimbursement a hospital in each peer group could be paid.

15. Between July 1, 1982 and July 1, 1986, the Medicaid Payment Program calculated quarterly ceilings by applying the Va. CPI, as recalculated quarterly, to inflate

each peer group median to provide for inflation during the cost reporting period for which a rate was being set. The medians were not otherwise adjusted during any one fiscal year, but were inflated (not recomputed based upon actual costs) each subsequent July 1 based upon an updated Va. CPI. Up until July 1, 1986, quarterly peer group ceilings were calculated based on that year's median and the subsequent, quarterly Va. CPI.

16. Since July 1, 1986, the Medicaid Payment Program has employed a "medical care index (hereinafter the "MCI") as an inflation factor in setting quarterly peer group ceilings following the same adjustment approach it followed with the Va. CPI.

17. The per diem reimbursement rates established pursuant to Virginia's Medicaid Payment Program do not conform to the requirements of the Medicaid Act in that they have not reasonably nor adequately met the costs incurred by efficiently and economically operated hospitals in providing care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards to Medicaid patients.

18. In particular, a VHA study of all hospital cost reports covering cost report periods which began between October 1, 1982 through September 30, 1983 showed that approximately 95% of all hospitals in the Medicaid Payment Program in Virginia incurred costs necessary to provide care to Medicaid patients in excess of their individual peer group ceilings on reimbursement despite efficient and economical operation. At the outset of these cost reports, the Virginia Medicaid Payment Program projected that approximately 25% (*not* 50%) of them

would incur costs at or below the peer group ceilings established. Because these cost reports began just three months subsequent to the establishment of the July, 1982 medians, it is apparent that those medians were not true medians and that hospitals had no reasonable nor adequate opportunity to be reimbursed the necessary cost of providing care to Virginia Medicaid patients.

19. This early trend has continued to the present time and is worsening. A study done by the Department of Medical Assistance Services, which included actual information for costs reports ending in 1984 and made various projections for FYE 1985, showed that less than 5% of the hospitals providing care to Virginia's Medicaid patients were projected to incur costs at or below the ceiling in FYE 1985. Upon information and belief, the VHA alleges that virtually all hospitals will actually incur costs in excess of their Medicaid payments in FYE 1987.

20. Deficiencies in the prospective payment system established by the Virginia Medicaid Payment Program stem from the fact that from July 1, 1982 to July 1, 1986, hospital peer group payment ceilings were tied to a general inflation factor which not only fails to reflect accurately the level of inflation experienced in the hospital industry, but also fails to consider factors other than inflation which cause the cost of care per patient day to increase at efficiently and economically operated hospitals. Among the factors causing hospital per diem costs to rise, besides inflation and irrespective of whether a general or medical care specific index is utilized, are: changes in technology; changes in care practices by physicians and hospitals; availability of nurses; treatment of more

patients, both medical and surgical, in outpatient departments; decreases in the average length of stay per hospital admission, due to the earlier discharge of patients to home recuperation or nursing home care and the shift of inpatients to outpatient care; and the increasing intensity of the inpatient services rendered per patient day.

21. Because the actual costs incurred by hospitals in their cost reporting periods ending in 1981 were inflated to create the medians established July 1, 1982 through the utilization of an index which did not accurately reflect inflation in the hospital industry and did not measure other factors which would cause the per diem cost of care to rise, the peer group medians and ceilings established initially were materially understated, and this understatement was compounded with each annual update.

22. Because the Medicaid peer group relied upon these understated medians and inflated them until July 1, 1986 by using an identically calculated index to anticipate the upcoming year's inflation, this computation further compounds the understatement inherent in the medians.

23. The MCI takes into account the cost inflation in medical goods and services and is a more accurate and sensitive measure of hospital cost inflation than the Va. CPI; however, Defendants have misapplied their own published regulations in implementing MCI adjustments to peer group ceilings. The Defendants have retroactively applied only half of the MCI adjustment in setting each quarterly peer group ceiling since July 1, 1986.

24. Even if the medical CPI as employed by Defendants does adequately measure hospital cost inflation from year to year, the historical understatement inherent

in the peer group ceilings persists and will continue to persist absent recomputation.

25. Furthermore, because peer group ceilings are computed quarterly based upon the medians created each July 1, the understatement is even worse for hospitals beginning a cost report period other than on July 1 because inflation that has been incurred from July 1 through the day the cost report period begins is not reflected in the ceiling calculation. For instance, a hospital beginning its cost report on June 1, 1983 would use as its base the median for July 1, 1982. A hospital starting its cost report period on July 1, 1983 would use as its base the July 1, 1983 median, which was computed by taking the July 1, 1982 median and inflating it for the past twelve months of inflation. Thus, though there would only be one month's difference in the timing of the cost reports, the first hospital would be deprived of eleven months of inflation in this comparison.

26. Based upon comparisons of hospital costs per patient day, Virginia hospitals are low cost health care providers. Virginia, though ranking above average nationally in per capita income, ranks below average nationally in cost per patient day.

27. When comparing costs nationally, Virginia's cost have increased at a percentage consistent with the average increase in inpatient costs nationally. The other factors, affecting cost per patient day other than inflation, have also similarly tracked national experience.

28. As a result of the Medicaid Payment Program initiated in Virginia in 1982, hospitals participating in the Virginia Medicaid program have been under-reimbursed

by tens of millions of dollars. For instance, using the Department's analysis of cost reports ending in 1984, and re-computing medians based upon that data and adjusting them only through the use of an MCI inflation factor, hospitals would have been reimbursed over \$13 million more for cost report periods ending in calendar year 1985 than under the current system. Such under-reimbursement has occurred in all years under the current Medicaid prospective payment system in Virginia and that disparity between cost and payment is increasing over time. For instance, a DMAS study of cost reports ending in 1984 showed the gap between payments and reimbursable costs to be approximately \$29,000,000.

29. Approximately 50% of hospitals participating in the Virginia Medicaid Payment Program are required to do so because they have received funds under the Public Health Services Act, 42 U.S.C. 291, *et seq.*, commonly known as the Hill-Burton Act. These funds were provided for the construction of hospitals and were conditioned upon a hospital making community service assurances. Current regulations require all such hospitals to make arrangements, if eligible to do so, for reimbursement for services with federal governmental third party programs, such as Medicare and Medicaid, and to take any necessary steps to assure that admission to and services of the facility are available to beneficiaries of the governmental programs without discrimination or preference because they are beneficiaries of those programs. 42 CFR § 124.603(c). Because of this requirement, hospitals subject to these Hill-Burton requirements are required to participate in the Virginia Medicaid Program irrespective

of their success or failure in meeting the cost efficiency and economy mandates of the Medicaid Act.

30. The March 3, 1986 amendments to Attachment 4.19-A (hereinafter referred to as the "Appeal Regulations") create an appeal system in an attempt to comply with this Court's Order in the case of *Mary Washington v. Fisher*, Civil Action No. 83-0551-R, decided January 4, 1985. Initially, the proposed effective date was August 22, 1985. Defendant Sorrell has advised the VHA that the true effective date would be the date upon which the Secretary of Health and Human Services approved of the appeal regulations. Such approval was issued on March 3, 1986. Prior to that time, at least 81 hospitals had filed appeals seeking relief for current and past cost reporting periods on grounds substantially similar to those set forth in this Complaint. The Appeal Regulations at Section 1.C. make these grounds of relief non-appealable items and, thereby, preclude the relief being sought by those hospitals.

31. The Defendants have promulgated the Appeal Regulations as just that, an appeals process, not as a substitute for a defective prospective payment system. The Health Care Financing Administration has accepted the Appeal Regulations only as a "hospital appeals process", and not as a substitute for a defective prospective payment system.

32. The Appeal Regulations are inadequate as an appeal system and as a substitute prospective payment system in that:

- (a) They are premised upon a false assumption that the current prospective payment system is consistent with federal law;
- (b) They prohibit the appeal of this false assumption by making the establishment of peer groups, medians and ceilings and the use of a general CPI up until July 1, 1986 and the MCI thereafter non-appeal issues;
- (c) They establish no concrete standard through which hospitals can reasonably anticipate what their rate will be set at before they begin a new cost report year;
- (d) They do not produce an administratively final "prospective payment rate" for the cost report period in question until 55 days after that cost report period has ended, assuming that the entire administrative process is utilized without any extensions of the established timeframes;
- (e) They establish a process for obtaining relief which is a subjective, case-by-case analysis through which hospitals must proceed individually;
- (f) They establish individual hearing process and proof requirement for each appeal which are so time consuming and expensive that the opportunity for group appeals of common issues is inherently necessary to a meaningful appeal process;
- (g) They combine the standards of economy and efficiency and access in determining the availability of relief to a hospital, such that a hospital that establishes that its costs are economically and efficiently incurred and are lower than the actual median costs incurred by other

hospitals in its peer group, can nevertheless be denied relief to which legally entitled under the access standard; and

(h) They are otherwise inconsistent with the Medicaid Act and do not provide a meaningful appeals system, especially in light of the underlying deficiencies in prospective payment under the Virginia Medicaid Payment Program.

33. The injury to Virginia hospitals described above is immediate, irreparable, and without an adequate remedy at law.

III. CAUSES OF ACTION

COUNT I

34. Plaintiff repeats and realleges the allegations set forth in paragraphs 1-33 of this Complaint.

35. Count I of this Complaint seeks a declaratory judgment pursuant to 28 U.S.C. §§ 2201, *et seq.* and 42 U.S.C. § 1983 that in enacting, enforcing and implementing Attachment 4.19-A to the Virginia State Plan under Title XIX of the Social Security Act, the Defendants, jointly and severally, have violated the provisions of the Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. § 1396, *et seq.*, and regulations promulgated thereunder, and their actions are therefore unconstitutional under the Supremacy Clause of the United States Constitution, Article VI, Section 2 thereof based upon the facts, circumstances and reasons set forth above.

COUNT II

36. Plaintiff repeats and realleges the allegations set forth in paragraphs 1-33 of this Complaint.

37. Count II of this Complaint seeks a declaratory judgment pursuant to 28 U.S.C. §§ 2201, *et seq.* and 42 U.S.C. § 1983 that Attachment 4.19-A of the Virginia State Plan under Title XIX of the Social Security Act, as amended, is unconstitutional under the Due Process Clause of the Fourteenth Amendment of the United States Constitution based upon the facts, circumstances and reasons set forth above.

COUNT III

38. Plaintiff repeats and realleges the allegations set forth in paragraphs 1-33 of this Complaint.

39. Count III of this Complaint seeks preliminary and permanent injunctive relief pursuant to Rule 65 of the Federal Rules of Civil Procedure and 42 U.S.C. § 1983 enjoining the enforcement of Attachment 4.19-A of the Virginia State Plan under Title XIX of the Social Security Act, as amended, in that the Plaintiff's member hospitals will be irreparably harmed by the continued operation of Attachment 4.19-A by being subject to an unapproved payment system and being denied the payment to which they are entitled under the Medicaid Act, 42 U.S.C. § 1396 *et seq.*, based upon the facts, circumstances and reasons set forth above.

WHEREFORE, the Plaintiff requests that the Court enter an Order herein granting to the Plaintiff the following relief:

1. A declaration that Attachment 4.19-A is unconstitutional under the Supremacy Clause and the Due Process Clause both as to the "Method and Standards for Establishing Payment Rates - In-Patient Care and the

"Final Regulations for Hospital Appeals of Reimbursement Rates".

2. A preliminary and a permanent injunction against the operation of Attachment 4.19-A of the Virginia State Plan under Title XIX of the Social Security Act, as amended, in particular the "Method and Standards of Establish Payment Rates - In-Patient Care" and the "Final Regulations for Hospital Appeals of Reimbursement Rates", such injunction to include:

(a) An Order that the Defendants promulgate and have approved by the Secretary of Health and Human Services a hospital payment system under the Virginia State Plan under Title XIX of the Social Security Act which complies with 42 U.S.C. § 1396 *et seq.*, and federal regulations adopted thereunder;

(b) An Order that pending such promulgation and approval the defendants in the interim are to reimburse hospitals participating in the Virginia State Plan at a level commensurate with payment under Title XVIII of the Social Security Act, as amended, commonly known as the Medicare Act; and

(c) An Order that the Defendants promulgate an appeals system which will enable hospitals participating in the Virginia State Plan under Title XIX of the Social Security Act to seek reimbursement for their cost reports still open to appeal by allowing them to directly attack the establishment of peer groups, medians, and ceilings and the use of a particular ceiling inflation index individually and by group appeal and which will otherwise provide a meaningful appeals system to hospitals.

Respectfully submitted,
THE VIRGINIA HOSPITAL
ASSOCIATION
By: /s/ Martin A. Donlan, Jr.
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CERTIFICATE OF SERVICE

I hereby certify that on this first day of February, 1988 that a true and accurate copy of the foregoing Amended Complaint was mailed, postage prepaid, to Roger L. Chaffe, Senior Assistant Attorney General, Commonwealth of Virginia, 101 North Eighth Street, Richmond, Virginia 23219.

/s/ Peter M. Mellette

*State of Virginia*METHODS AND STANDARDS FOR ESTABLISHING
PAYMENT RATES - IN-PATIENT CARE

The state agency will pay the reasonable cost of in-patient hospital services provided under the plan. In reimbursing hospitals for the cost of in-patient hospital services provided to recipients of medical assistance.

- I. For each hospital also participating in the Health Insurance for the Aged program under Title XVIII of the Social Security Act, the state agency will apply the same standards, cost reporting period, cost reimbursement principles, and method of cost apportionment currently used in computing reimbursement to such a hospital under Title XVIII of the Act, except that the in-patient routine services costs for medical assistance recipients will be determined subsequent to the application of the Title XVIII method of apportionment, and the calculation will exclude the applicable Title XVIII in-patient routine service charges or patient days as well as Title XVIII in-patient routine service cost.
- II. For each hospital not participating in the program under Title XVIII of the Act, the state agency will apply the standards and principles described in 42 CFR 447.250 and either (a) one of the available alternative cost apportionment methods in 42 CFR 447.250, or (b) the "Gross RCCAC method" of cost apportionment applied as follows: For a reporting period, the total allowable hospital in-patient charges; the resulting percentage is applied to the bill of each in-patient under the Medical Assistance Program.
- III. For either participating or non/participating facilities, the Medical Assistance Program will pay no more in the aggregate for inpatient hospital services than the amount it is estimated would be paid for

the services under the Medicare principles of reimbursement, as set forth in 42 CFR 447.253(b)(2), and/or lesser of reasonable cost or customary charges in 42 CFR 447.250.

- IV. The state agency will apply the standards and principles as described in the state's reimbursement plan approved by the Secretary on a demonstration or experimental basis for the payment of reasonable costs by methods other than those described in paragraphs a and b above.

TN No. _____ Approval Date FEB 23 1988
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Supercedes

TN No. _____

- V. The reimbursement system for hospitals includes the following components:

- (1) Hospitals should be grouped by classes according to number of beds and urban versus rural. (Three groupings for rural - less than 100 beds, 101 to 170 beds, and over 171 beds; four groupings for urban - less than 100, 100 to 400 to 401 to 600, and over 601 beds.) Groupings are similar to those used by the Health Care Financing Administration (HCFA) in determining routine cost limitations.
- (2) Prospective reimbursement ceilings on allowable operating costs should be established as of July 1, 1982, for each grouping. Hospitals with a fiscal year end after June 30, 1982 shall be subject to the new reimbursement ceilings.

The calculation of the initial group ceilings as of July 1, 1982, should be based on available, allowable cost data for all hospitals in calendar year 1981. Individual hospital operating costs should be advanced by a reimbursement escalator from the hospital's year end to July 1, 1982. After this advancement, the operating costs

should be standardized using SMSA wage indices, and median should be determined for each group. These medians should be readjusted by the wage index to set an actual cost ceiling for each SMSA. Therefore, each hospital grouping should have a series of ceilings representing one of each SMSA area. The wage index should be based on those used by HCFA in computing its Market Basket Index for routine cost limitations.

Effective July 1, 1986, providers subject to the prospective payment system of reimbursement will have their prospective operating cost rate and prospective operating cost ceiling computed using a new methodology. This new method will use an allowance for inflation based on the percent of change in the quarterly average of the Medical Care Index of the Chase Econometrics - Standard Forecast determined in the quarter in which the provider's new fiscal year begins.

The prospective operating cost rate will be based on the provider's allowable cost from the most recent filed cost report, plus the inflation percentage add-on.

The prospective operating cost ceiling will be determined by using the base that was in effect for the provider's fiscal year that began between July 1, 1985, and June 1, 1986. The medical care index percent of change for the quarter in which the provider's new fiscal year began will be added to this base to determine the new operating cost ceiling. This new ceiling is to be effective for all providers on July 1, 1986. For subsequent cost reporting periods beginning on or after July 1, 1986, the last prospective operating rate ceiling determined under this new methodology will become the

base for computing the next prospective year ceiling.

TN No. _____ Approval Date MAR 16 1987

EFFECTIVE: 7-1-86
Dept Med Assn Svc
TRANSMITTAL NO: 86-06

The new method will still require comparison of the prospective operating cost rate to the prospective operating ceiling. The provider is allowed the lower of the two amounts subject to the lower of cost or charges principles.

- (3) Subsequent to June 30, 1982, the group ceilings should not be recalculated on allowable costs, but should be updated by the escalator.
- (4) Prospective rates for each hospital should be based upon the hospital's allowable costs plus the escalator, or the appropriate ceilings, or charges; whichever is lower. Except to eliminate costs that are found to be unallowable, no retrospective adjustment should be made to prospective rates.
Depreciation, capital interest, and education costs approved pursuant to HIM-15 (Sec. 400), should be considered as pass throughs and not part of the calculation.
- (5) Hospitals which have a disproportionately higher level of Medicaid patients and which exceed the ceiling should be allowed a higher ceiling based on the individual hospital's Medicaid utilization. This should be measured by the percent of Medicaid patient days to total hospital patient days. Each hospital with a Medicaid utilization of over 8% should receive an adjustment to its ceiling. The adjustment should be set at a percent added to the ceiling for each percent of utilization up to 30%.

- (6) There will be special consideration for exception to the median operating cost limits in those instances where extensive neonatal care is provided.
- (7) An incentive plan should be established whereby a hospital will be paid on a sliding scale, percentage for percentage, up to 25% of the difference between allowable operating costs and the appropriate per diem group ceiling when the operating costs are below the ceilings. The incentive should be calculated based on the annual cost report.

The table below presents three examples under the new plan:

Group Ceiling	Hospital's Allowable Cost Per Day	Sliding Scale Incentive			
		Difference \$	% of Ceiling	\$	% of Difference
\$230	\$230	-0-	-0-	-0-	-0-
230	207	23.00	10%	2.30	10%
230	172	57.50	25%	14.38	25%
230	143	76.00	33%	19.00	25%

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VI. In accordance with the requirements of Section 1902(a)(13)(A) of the Social Security Act and in accordance with the regulations at 42 CFR 447.250 through 447.272, the Virginia Medical Assistance Program will continue using the Medicare retrospective cost system guidelines to determine allowable costs for Virginia's prospective payment system. Virginia adheres to the Medicare principles in effect prior to October 1, 1983.

VII. Reevaluation of Assets

- A. Effective October 1, 1984, the valuation of an asset of a hospital or long - term care facility which has undergone a change of ownership on or after July 18, 1984, shall be the lesser of the allowable acquisition cost to the owner of record as of July 18, 1984, or the acquisition cost to the new owner.
- B. In the case of an asset not in existence as of July 18, 1984, the valuation of an asset of a hospital or long-term care facility shall be the lesser of the first owner of record, or the acquisition cost to the new owner.
- C. In establishing an appropriate allowance for depreciation, interest on capital indebtedness, and return on equity (if applicable prior to July 1, 1986) the base to be used for such computations shall be limited to A or B above.
- D. Costs (including legal fees, accounting and administrative costs, travel costs, and feasibility studies) attributable to the negotiation or settlement of the sale or purchase of any capital asset (by acquisition or merger) shall be reimbursable only to the extent that they have not been previously reimbursed by Medicaid.
- E. The recapture of depreciation up to the full value of the asset is required.
- F. Rental charges in sale and leaseback agreements shall be restricted to the depreciation, mortgage interest and (if applicable prior to July 1, 1986) return on equity based on the cost of ownership as determined in accordance with A and B above.

TN No. _____ Approval Date FEB 23 1988
Effective Date JUL 31 1987

Supercedes

TN No. _____

VIII. Refund of Overpayments – Effective July 1, 1986

- A. *Lump Sum Payment.* When the provider files a cost report indicating that an overpayment has occurred, full refund is to be remitted with the cost report, or, in cases where DMAS discovers an overpayment during desk review, field audit, or final settlement, DMAS will immediately send the first demand letter requesting a lump sum refund. Recovery will be undertaken even though the provider disputes in whole or in part DMAS's determination of the overpayment.
- B. *Payment Schedule.* If the provider cannot refund the total amount of the overpayment within thirty (30) days after receiving the letter, the provider should immediately request an extended repayment schedule. DMAS may establish a repayment schedule of up to twelve (12) months to recover all or part of an overpayment.

It must offset any money owed to the provider prior to establishing a repayment plan. When a repayment schedule is used to recover only part of an overpayment, the remaining amount should be recovered by the reduction of interim payments to the provider or by lump sum payments.

- C. *Extension Request Documentation.* The provider must document its need for extended (beyond thirty (30) days repayment and resubmit a written proposal scheduling the dates and amounts of repayments. The Program will send the provider written notification of the approved repayment schedule, which will be in effect from the date the provider submits the proposal. If an audit later uncovers an additional overpayment, the provider must submit further documentation if it wishes to

request an extended repayment schedule for the additional amount.

- D. *Interest Charge on Extended Repayment.* Interest will be charged to the provider at the rate specified in Section 32.1-313 of the *Code of Virginia* (1950) as amended, on the unpaid balance of the approved repayment schedule. Interest will accrue from the date the overpayment is determined. Interest will not be charged or accrued during the period of the Program's administrative review. Interest will be charged on any unpaid balance from the date of the Director's final administrative determination.

In any case in which any initial determination of overpayment has been reversed in a subsequent judicial proceeding, the provider shall be reimbursed that portion of the payment to which he is entitled, plus any applicable interest paid.

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Dept Med Assn Svc
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- IX. Effective October 1, 1986, hospitals that have obtained Medicare certification as inpatient rehabilitation hospitals or rehabilitation units in acute care hospitals, which are exempted from the Medicare Prospective Payment System (DRG), shall be reimbursed in accordance with the current Medicaid Prospective Payment System as described in the preceding sections I, II, III, IV, V (excluding (6)), VI, VII, VIII. Additionally, rehabilitation hospitals and rehabilitation units of acute care hospitals which are exempt from the Medicare Prospective Payment System will be required to maintain separate cost accounting records, and to file separate cost reports

annually utilizing the applicable Medicare cost reporting forms, (HCFA 2552 series), and the Medicaid forms (MAP-783 series).

A new facility shall have an interim rate determined using a pro forma cost report or detailed budget prepared by the provider and accepted by DMAS, which represents its anticipated allowable cost for the first cost reporting period of participation. For the first cost reporting period, the provider will be held to the lesser of its actual operating costs or its peer group ceiling. Subsequent rates will be determined in accordance with the current Medicaid Prospective Payment System as noted in the preceding paragraph of IX.

- X. Item 398 D of the 1987 Appropriation Act (as amended), effective April 8, 1987, eliminated reimbursement of return on equity capital to proprietary providers.

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Supercedes

TN No. _____

FINAL REGULATIONS FOR HOSPITAL APPEALS OF REIMBURSEMENT RATES

§ 1. RIGHT TO APPEAL AND INITIAL AGENCY DECISION

A. Right to Appeal: Any hospital seeking to appeal its prospective payment rate for operating costs related to inpatient care or other allowable costs shall submit a written request to the Department of Medical Assistance Service within 30 days of the date of the letter notifying the hospital of its prospective rate unless permitted to do otherwise under § 5E. The written request for appeal

must contain the information specified in § 1B. The Department shall respond to the hospital's request for additional reimbursement within 30 days or after receipt of any additional documentation requested by the Department, whichever is later. Such agency response shall be considered the initial agency determination.

B. Required Information: Any request to appeal the prospective payment rate must specify: (i) the nature of the adjustment sought; (ii) the amount of the adjustment sought; and (iii) current and prospective cost containment efforts, if appropriate.

C. Non-Appealable Issues: The following issues will not be subject to appeal: (i) the organization of participating hospitals into peer groups according to location and bed size and the use of bed size and the urban/rural distinction as a generally adequate proxy for case mix and wage variations between hospitals in determining reimbursement for inpatient care; (ii) the use of Medicaid and applicable Medicare Principles of Reimbursement to determine reimbursement of costs other than operating costs relating to the provision of inpatient care; (iii) the calculation of the initial group ceilings on allowable operating costs for inpatient care as of July 1, 1982; (iv) the use of the Bureau of Labor Statistics Consumer Price Index (CPI) (excluding housing and interest components) as the prospective escalator; and (v) durational limitations set forth in the State Plan (the "twenty-one day rule").

D. The rate which may be appealed shall include costs which are for a single cost reporting period only.

E. The hospital shall bear the burden of proof throughout the administrative process.

§ 2. ADMINISTRATIVE APPEAL OF ADVERSE INITIAL AGENCY DETERMINATION

A. *General:* The administrative appeal of an adverse initial agency determination shall be made in accordance with the Virginia Administrative Process Act, §§ 9-6.14:11 through 9-6.14:14 of the Code of Virginia, as set forth below.

B. *The Informal Proceeding:*

1. The hospital shall submit a written request to appeal an adverse initial agency determination in accordance with § 9-6.14:11 of the Code of Virginia within 15 days of the date of the letter transmitting the initial agency determination.

2. The request for an informal conference in accordance with § 9-6.14:11 of the Code of Virginia shall include the following information:

- a. the adverse agency action appealed from;
- b. a detailed description of the factual data, argument or information the hospital will rely on to challenge the adverse agency decision.

3. The agency shall afford the hospital an opportunity for an informal conference in accordance with § 9-6.14:11 of the Code of Virginia within 45 days of the request.

4. The Director of the Division of Provider Reimbursement of the Department of Medical Assistance

Services, or his designee, shall preside over the informal conference. As hearing officer, the Director, or his designee, may request such additional documentation or information from the hospital or agency staff as may be necessary in order to render an opinion.

5. After the informal conference, the Director of the Division of Provider Reimbursement, having considered the criteria for relief set forth in §§ 4 and 5, shall take any of the following actions:

- a. notify the provider that its request for relief is denied setting forth the reasons for such denial; or
- b. notify the provider that its appeal has merit and advise it of the agency action which will be taken; or
- c. notify the provider that its request for relief will be granted in part and denied in part, setting forth the reasons for the denial in part and the agency action which will be taken to grant relief in part.

6. The decision of the informal hearing officer shall be rendered within 30 days of the conclusion of the informal conference.

§ 3. THE FORMAL ADMINISTRATIVE HEARING: PROCEDURES

A. The hospital shall submit its written request for a formal administrative hearing under § 9-6.14:12 of the Code of Virginia within 15 days of the date of the letter transmitting the adverse informal agency decision.

B. At least 21 days prior to the date scheduled for the formal hearing, the hospital shall provide the agency with:

1. Identification of the adverse agency action appealed from, and

2. A summary of the factual data, argument and proof the provider will rely on in connection with its case.

C. The agency shall afford the provider an opportunity for a formal administrative hearing within 45 days of the receipt of the request.

D. The Director of the Department of Medical Assistance Services, or his designee, shall preside over the hearing. Where a designee presides, he shall make recommended findings and a recommended decision to the Director. In such instance, the provider shall have an opportunity to file exceptions to the proposed findings and conclusions. In no case shall the designee presiding over the formal administrative hearing be the same individual who presided over the informal appeal.

E. The Director of the Department of Medical Assistance Services shall make the final administrative decision in each case.

F. The decision of the agency shall be rendered within 60 days of the conclusion of the administrative hearing.

§ 4. THE FORMAL ADMINISTRATIVE HEARING: NECESSARY DEMONSTRATION OF PROOF

A. The hospital shall bear the burden of proof in seeking relief from its prospective payment rate.

B. A hospital seeking additional reimbursement for operating costs relating to the provision of inpatient care

shall demonstrate that its operating costs exceed the limitation on operating costs established for its peer group and set forth the reasons for such excess.

C. In determining whether to award additional reimbursement to a hospital for operating costs relating to the provision of inpatient care, the Director of the Department of Medical Assistance Services shall consider the following:

1. Whether the hospital has demonstrated that its operating costs are generated by factors generally not shared by other hospitals in its peer group. Such factors may include, but are not limited to, the addition of new and necessary services, changes in case mix, extraordinary circumstances beyond the control of the hospital, and improvements imposed by licensing or accrediting standards.

2. Whether the hospital has taken every reasonable action to contain costs on a hospital-wide basis.

a. In making such a determination, the Director or his designee may require that an appellant hospital provide quantitative data, which may be compared to similar data from other hospitals within that hospital's peer group or from other hospitals deemed by the Director to be comparable. In making such comparisons, the Director may develop operating or financial ratios which are indicators of performance quality in particular areas of hospital operation. A finding that the data or ratios or both of the appellant hospital fall within a range exhibited by the majority of comparable hospitals, may be construed by the Director to be

evidence that the hospital has taken every reasonable action to contain costs in that particular area. Where applicable, the Director may require the hospital to submit to the agency the data it has developed for the Virginia Health Services Cost Review Commission. The Director may use other data, standards or operating screens acceptable to him. The appellant hospital shall be afforded an opportunity to rebut ratios, standards or comparisons utilized by the Director or his designee in accordance with this section.

- b. Factors to be considered in determining effective cost containment may include the following:
 - Average daily occupancy
 - Average hourly wage
 - FTE's per adjusted occupied bed
 - Nursing salaries per adjusted patient day
 - Average length of stay
 - Average cost per surgical case
 - Cost (salary/non-salary) per ancillary procedure
 - Average cost (food/non-food) per meal served
 - Average cost per pound of laundry
 - Cost (salary/non-salary) per pharmacy prescription
 - Housekeeping cost per square foot
 - Maintenance cost per square foot
 - Medical records cost per admission
 - Current Ratio (current assets to current liabilities)

- Age of receivables
- Bad debt percentage
- Inventory turnover
- Measures of case mix
- c. In addition, the Director may consider the presence or absence of the following systems and procedures in determining effective cost containment in the hospital's operation.
 - Flexible budgeting system
 - Case mix management systems
 - Cost accounting systems
 - Materials management system
 - Participation in group purchasing arrangements
 - Productivity management systems
 - Cash management programs and procedures
 - Strategic planning and marketing
 - Medical records systems
 - Utilization/Peer review systems
- d. Nothing in this provision shall be construed to require a hospital to demonstrate every factor set forth above or to preclude a hospital from demonstrating effective cost containment by using other factors.

The Director or his designee may require that an onsite operational review of the hospital be conducted by the Department or its designee.

3. Whether the hospital has demonstrated that the Medicaid prospective payment rate it receives to

cover operating costs related to inpatient care is insufficient to provide care and service that conforms to applicable state and federal laws, regulations and quality and safety standards.¹

D. In no event shall the Director of the Department of Medical Assistance Services award additional reimbursement to a hospital for operating costs relating to the provision of inpatient care, unless the hospital demonstrates to the satisfaction of the Director that the Medicaid rate it receives under the Medicaid prospective payment system is insufficient to ensure Medicaid recipients reasonable access to sufficient inpatient hospital services of adequate quality.² In making such demonstration, the hospital shall show that:

1. The current Medicaid prospective payment rate jeopardizes the long-term financial viability of the hospital. Financial jeopardy is presumed to exist if, by providing care to Medicaid recipients at the current Medicaid rate, the hospital can demonstrate that it is, in the aggregate, incurring a marginal loss³.

For purposes of this section marginal loss is the amount by which total variable costs for each patient day exceed the Medicaid payment rate. In calculating marginal loss, the hospital shall compute variable costs at 60% of total inpatient operating costs and fixed costs at 40% of total inpatient operating costs; however, the Director may accept a different ratio of fixed and variable operating costs if a hospital is able to demonstrate that a different ratio is appropriate for its particular institution.

Financial jeopardy may also exist if the hospital is incurring a marginal gain but can demonstrate that it has

unique and compelling Medicaid costs, which if unreimbursed by Medicaid, would clearly jeopardize the hospital's long-term financial viability and,

2. The population served by the hospital seeking additional financial relief has no reasonable access to other inpatient hospitals. Reasonable access exists if most individuals served by the hospital seeking financial relief can receive inpatient hospital care within a 30 minute travel time at a total per diem rate which is less to Department of Medical Assistance Services than the costs which would be incurred by DMAS per patient day were the appellant hospital granted relief.⁴

E. In determining whether to award additional reimbursement to a hospital for reimbursable costs which are other than operating costs related to the provision of inpatient care, the Director shall consider Medicaid and applicable Medicare rules of reimbursement.

§ 5. AVAILABLE RELIEF

A. Any relief granted under §§ 1-4 shall be for one cost reporting period only.

B. Relief for hospitals seeking additional reimbursement for operating costs incurred in the provision of inpatient care shall not exceed the difference between:

1. The cost per allowable Medicaid day arising specifically as a result of circumstances identified in accordance with § 4 (excluding plant and education costs and return on equity capital) and

2. The prospective operating cost per diem, identified in the Medicaid Cost Report and calculated by DMAS.⁵

C. Relief for hospitals seeking additional reimbursement for (i) costs considered as "pass-throughs" under the prospective payment system or (ii) costs incurred in providing care to a disproportionate number of Medicaid recipients or (iii) costs incurred in providing extensive neonatal care shall not exceed the difference between the payment made and the actual allowable cost incurred.

D. Any relief awarded under §§ 1-4 shall be effective from the first day of the cost period for which the challenged rate was set. Cost periods for which relief will be afforded are those which begin on or after January 4, 1985. In no case shall this limitation apply to a hospital which noted an appeal of its prospective payment rate for a cost period prior to January 4, 1985.

E. All hospitals for which a cost period began on or after January 4, 1985, but prior to the effective date of these regulations, shall be afforded an opportunity to be heard in accordance with these regulations if the request for appeal set forth in § 1A is filed within ninety days of the effective date of these regulations.

§ 6. CATASTROPHIC OCCURRENCE

A. Nothing in §§ 1 through 5 shall be construed to prevent a hospital from seeking additional reimbursement for allowable costs incurred as a consequence of a natural or other catastrophe. Such reimbursement will be paid for the cost period in which such costs were

incurred and for costs periods beginning on or after July 1, 1982.

B. In order to receive relief under this section, a hospital shall demonstrate that the catastrophe met the following criteria:

1. One time occurrence;
2. Less than twelve months duration;
3. Could not have been reasonably predicted;
4. Not of an insurable nature;
5. Not covered by federal or state disaster relief;
6. Not a result of malpractice or negligence.

C. Any relief sought under this section must be calculable and auditable.

D. The agency shall pay any relief afforded under this section in a lump sum.

¹ See 42 U.S.C. § 1396 (a)(13)(A). This provision reflects the Commonwealth's concern that she reimburse only those excess operating costs which are incurred because they are needed to provide adequate care. The Commonwealth recognizes that hospitals may choose to provide more than "just adequate" care and, as a consequence, incur higher costs. In this regard, the Commonwealth notes that "Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services . . . that package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered - not 'adequate health care'." Alexander

v. Choate, ___ U.S. ___ decided January 9, 1985, 53 U.S.L.W. 4072, 4075.

² In *Mary Washington Hospital v. Fisher*, the court ruled that the Medicaid rate "must be adequate to ensure reasonable access". *Mary Washington Hospital v. Fisher*, at p. 18. The need to demonstrate that the Medicaid rate is inadequate to ensure recipients reasonable access derives directly from federal law and regulation. In its response to comments on the NPRM published September 30, 1981, HCFA points out Congressional intent regarding the access issue:

The report on H.R. 3982 states the expectation that payment levels for inpatient services will be adequate to assure that a sufficient number of facilities providing a sufficient level of services actively participate in the Medicaid program to enable all Medicaid beneficiaries to obtain quality inpatient services. This report further states that payments should be set at a level that ensures the active treatment of Medicaid patients in a majority of the hospitals in the state.

46 Fed. Reg. 47970.

³ The Commonwealth believes that Congressional intent is threatened in situations in which a hospital is incrementally harmed for each additional day a Medicaid patient is treated – and therefore has good cause to consider withdrawal from the program – and where no alternative is readily available to the patient, should withdrawal occur. Otherwise, although the rate being paid a hospital may be less than that paid by other payors – indeed, less than *average* cost per day for all patients – it nonetheless equals or exceeds the variable cost per day, and therefore benefits the hospital by offsetting some amount of fixed costs, which it would incur even if the bed occupied by the Medicaid patient were left empty.

It should be emphasized that application of this marginal loss or "incremental harm" concept is a device to assess the potential harm to a hospital continuing to treat Medicaid recipients, and not a mechanism for determining the additional payment due to a successful appellant. As discussed below,

once a threat to access has been demonstrated, the Commonwealth may participate in the full average costs associated with the circumstances underlying the appeal.

⁴ With regard to the thirty minute travel standard, this requirement is consistent with general health planning criteria regarding acceptable travel time for hospital care.

⁵ The Commonwealth recognizes that in cases where circumstances warrant relief beyond the existing payment rate, she may share in the cost associated with those circumstances. This is consistent with the existing policy, whereby payment is made on an average per diem basis. The Commonwealth will not reimburse more than her share of fixed costs. Any relief to an appellant hospital will be computed using patient days adjusted for the level of occupancy during the period under appeal. In no case will any additional payments made under this rule reflect lengths of stay which exceed the twenty-one day limit currently in effect.

AFFIDAVIT

I, J. John McMahon state as follows:

1. I am currently employed as Vice President/Finance of the Virginia Hospital Association, (VHA), a position I have held since October 17, 1986.

2. In my position, I have become familiar with figures, provided to VHA by the State Department of Medicaid Assistance Services (DMAS), reflecting Medicaid and Medicare costs and reimbursement for member hospitals of the Virginia Hospital Association.

3. It is standard practice for VHA member hospitals to file Medicaid cost reports three months after the end of each Hospital's fiscal year. These reports are not audited for some time thereafter. Because of this time lag in reporting and auditing figures, 1986 is the last year for which information is currently available.

4. In 1982, the difference between Medicaid costs, determined to be reasonable and necessary after state and Federal audits, and Medicaid reimbursement of such costs was \$2,178,157. This shortfall increased to \$15,810,254 in 1983, to \$19,277,523 in 1984, to \$28,477,491 in 1985 and to \$29,233,350 in 1986.

5. In 1983, on average, the reimbursement shortfall per Medicaid patient day was \$46.91. In 1986, the average reimbursement shortfall per Medicaid patient day was \$92.30.

6. In my position, I have also become familiar with the VHA's hospital membership, the VHA membership dues assessment method, and the VHA's effort in collecting those dues.

7. VHA member dues are assessed and payable in a lump sum on or about January 1 of each year.

8. Since 1982, I am aware of increasing instances in which hospital members have been unable to pay their annual assessments in full and on time. Those hospitals claimed financial hardship as a result of an inability to cover their patient care costs and provide needed services within the reimbursement levels of third party payors, including Medicaid.

9. Since 1982, I am also aware of hospitals who have allowed their VHA membership to lapse due to financial hardship, again resulting from an inability to cover their patient care costs and provide needed services within the reimbursement levels of third party payors, including Medicaid.

Pursuant to 28 U.S.C. § 1746, I hereby state under penalty of perjury that the foregoing is true and correct.

/s/ J. John McMahon
J. JOHN McMAHON

STATE OF VIRGINIA

CITY/COUNTY OF Henrico, to-wit:

Subscribed and sworn to before me this 24th day of February, 1988.

My commission expires: 4/16/91

/s/ Susan H. Pangelman
Notary Public

IN THE UNITED STATES DISTRICT
COURT FOR THE EASTERN DISTRICT
OF VIRGINIA Richmond Division

THE VIRGINIA)	
HOSPITAL ASSOCIATION,)	
	Plaintiff,)
v.)	CIVIL ACTION
GERALD L. BALILES, <i>et al.</i> ,)	NO.
)	86-1066-R
Defendants.)	

AFFIDAVIT

COMMONWEALTH OF VIRGINIA
to-wit,

I, Joseph Becht, being duly sworn do affirm and state:

1. I am presently Senior Manager, Health Care Consulting, with the firm of Ernst and Whinney.
2. I am familiar with the prospective payment system used by the Commonwealth of Virginia to reimburse hospitals participating in the State Medical Assistance Program and with recent proposed changes to this system.
3. Attached hereto and incorporated herein by this reference is a true and accurate copy of my curriculum vitae.
4. In the course of preparing this affidavit, I have reviewed the pleadings to date in this case, including the affidavits of Messers Nelson Ford and Ray T. Sorrell.
5. The facts set forth herein are based upon my personal knowledge and the records of the Department of Medical Assistance Services. ("DMAS") The opinions

expressed are based upon my knowledge and experience in health care financial management and upon information regularly relied upon by health care financial managers in forming opinions and advising health care providers with respect to third party reimbursement and other financial management issues.

6. Scientific and technological advancements are known to cause hospital operating costs both to rise and fall. A recent analysis performed by the Prospective Payment Assessment Commission ("PRO PAC"), a federal commission created to annually advise the Secretary of Health and Human Services on an appropriate update factor for Medicare prospective payments to hospitals and on needed changes in the diagnosis-related groups (DRGs) on which Medicare reimbursement is based, similarly concluded that such advances cause operating cost to rise and fall. See CCH Medicare and Medicaid Guide, Extra Edition, No. 520, April 21, 1987. PRO PAC's report concluded that scientific and technological advances, however, caused a net increase in hospital costs. It is my opinion that PRO PAC's determination is valid and that the net effect of future technological and scientific advances has caused and is likely to continue to cause hospital operating costs to rise independent of inflation.

7. In addition to the above, it is important to note that the PRO PAC assessment of the impact of scientific and technological advances is based upon costs per hospital admission, not costs per hospital day. Because, as noted below, the average length of stay per admission has been decreasing, there is good reason to expect that those advances which reduce cost per case will not necessarily reduce the cost per day for the remaining days in an

admission. In fact, it is more probable that they will increase the per day cost for such days because at a minimum there are fewer days over which to spread fixed operating costs.

8. The Virginia Medicaid Program, a per diem reimbursement system, in fact provides no incentive to reduce a patient's length of stay because such a reduction directly reduces the amount of reimbursement received for a patient's care. On the other hand, a reduction in average length of stay provides the quickest and greatest savings to such a payor. For instance, based upon the statistical information published by DMAS, "Reimbursement Methodology Study, Phase III Report, Input and Output Hospital Reimbursement Alternatives, March 1987," total Medicaid days dropped from 375,273 to 301,154, but Medicaid discharges only dropped from 60,399 to 57,404. The result is a decline in average Medicaid length of stays from 6.22 days in 1982 to 5.25 days in 1986. For cost report periods ending in 1986, Medicaid reimbursable days were reimbursed at an average rate of \$346.23 per day, based upon a DMAS study referenced as "DMAS Model Name: HTEMPLAT-Revised Data-Updated 9/11/87." ("Revised Data") Given the 57,404 discharges in 1986, if Medicaid length of stays had not declined by approximately one day since 1982, there would have been 57,404 additional days charged to the Medicaid Program. The total savings realized by the Medicaid Program amounted to approximately \$19.8 million based upon the 1986 average reimbursement per patient day.

9. As noted in Mr. Ford's affidavit, there are variables such as changes in length of stay, productivity increases, changes in medical practices, and scientific and

technological advances which impact upon hospital costs. In other words, there are variables in addition to inflation which will cause hospital costs per day to rise or fall. Admittedly, the Medicaid program does not measure these variables because it uses a simple inflator as an update factor for Virginia's prospective payment system. Such factors can be measured. The failure to measure these variables indicates that the defendants have not developed the necessary information to assure the Secretary annually that their rates are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities and to assure Medicaid beneficiaries reasonable access to inpatient services of adequate quality. 42 C.F.R. § 447.253(a) (b). If it is true, as Mr. Ford suggests, that the measurement of such variables is impossible, then DMAS cannot give the necessary assurances required of state medical assistance programs.

10. The principle theme of the Virginia Medicaid Program is set forth in the affidavit of Mr. Ford, paragraph 10 as follows:

Under prospective payment principles, there is no direct relationship between payment rates and those costs needed to function in an efficient and economic manner.

This statement is absolutely true for the Virginia Medicaid prospective payment system. However, if a Medicaid program is to set rates which are "reasonable and adequate to meet the costs which must be incurred by the efficiently and economically operated facilities" there must be a "direct relationship between payment rates" and "needed costs". It is this lack of a direct relationship, which has largely been created by the use of an update

factor which measures only one of the applicable variables, i.e., inflation, which has caused the dramatic disparity between hospital reimbursement and Medicaid allowable costs.

11. While prospective rates are set in advance, they cannot be set so low that hospital are not reimbursed their "needed costs" of providing care; otherwise, any appeal system becomes an *ad hoc* rate system because many hospitals will require and should be entitled to relief from such rates.

12. Prospective payments systems should include an "appropriate escalator" which considers the effects of inflation along with changes in length of stay, productivity increases, changes in medical practices, scientific and technological advancements, and other factors. The Health Care Financing Administration uses an "update factors" which includes not only an "inflator" but also considers other variables.

13. The variables which should be considered when setting update factors, however, can impact on per diem and per case systems differently. For example, assume that all variables remain constant except average length of stay. In a hypothetical surgical admission, next assume that on the first day of hospitalization the patient has surgery, the second day he receives care in a special care unit, and the remaining days he receives care in a routine area. The operating costs per day in such a case would typically be highest on the first day and lowest on the last day. For this example, assume that the operating costs on Day 1 = \$1,000; Day 2 = \$600; Day 3 = \$400; Day 4 = \$350; Day 5 = \$350; Day 6 = \$300. These assumptions yield an

operating cost per case of \$3,000 and an average cost per day of \$500. Assume further that the average length of stay declines by one day. Lastly, as is common, that the decrease in the length of stay is caused by the patient being discharged earlier. Using the Virginia Medicaid appeal regulations assumption that 60% of operating costs are variable and 40% are fixed, the need for downward adjustment in the cost per case and an upward adjustment in the cost per day inflator becomes apparent. Under the per case system, the hospital would arguably save the variable operating costs incurred on the last day, some \$180. Thus, the cost to the hospital is not \$3,000, but may be as low as \$2,820. The hospital under a per case payment has a potential profit or productivity benefit of \$180 if changes in length of stay are not factored into the "update factor". Under the per diem system which pays the average cost of \$500, the hospital is paid for five days for a total of \$2500. The hospital has at least a \$320 loss assuming it can avoid all variable costs for the last day. Though simplistic, this example, in large part, explains one of the basic defects of the Virginia Medicaid prospective payment system.

14. Medicaid allowable costs do not represent "all costs expended by . . . hospitals in all 'allowable' categories defined by Medicare", as stated in Mr. Sorrell's affidavit. Hospitals may only claim allowable costs which are reasonable and necessary to patient care. If costs claimed do not meet this standard, they would not be allowed by Medicare.

15. Medicaid does represent about 5.4% of hospital revenues and patient days in Virginia. Based upon DMAS' Revised Data for 1986, DMAS reimbursement

levels were \$29,233,350 below Medicaid hospital allowable costs in 1986. However, if Medicaid rates were paid by all payors, Virginia hospitals would have incurred approximately \$520,000,000 in unreimbursed, Medicaid allowable, operating costs. They would have to cover these costs out of their existing reserves. Needless to say, such losses would have been devastating to the health care system in Virginia.

16. The Final Regulations For Hospital Appeals Of Reimbursement Rates ("Appeal Regulations") prohibit appeal of the systemic defects in the DMAS prospective payment system. See Appeal Regulations Section 1.C. Additionally, to obtain relief, a hospital must demonstrate that its operating costs in excess of its payment rate are generated "by factors not generally shared by other hospitals in its peer group." See Appeal Regulations Section 4.C.2. The Appeals Regulations also condition relief upon a financial jeopardy analysis. See Appeals Regulations Section 4.D.1. First, a hospital must show it has a marginal loss, i.e., that its Medicaid rate is insufficient to pay 60% of its operating costs. Alternatively, a hospital without a marginal loss may obtain relief if it has "unique and compelling Medicaid costs, which if unreimbursed by Medicaid, would clearly jeopardize the hospitals' long-term financial viability". Again, because the factors causing a hospital to exceed its Medicaid payment rate are generally common to all hospitals, such cost will not be "unique".

/s/ Joseph Becht
Joseph Becht

Subscribed and sworn to before me this 18th day of March, 1988.

/s/ Ruth Ann Toney
Notary Public

My Commission expires: October 6, 1988

IN THE UNITED STATES DISTRICT
COURT FOR THE EASTERN DISTRICT
OF VIRGINIA Richmond Division

THE VIRGINIA) CIVIL ACTION
HOSPITAL ASSOCIATION,) NO.
Plaintiff,) 86-1066-R
v.)
GERALD L. BALILES, *et al.*,) (Filed
Defendants.) Mar. 25, 1988)

ORDER

Deeming it just and proper so to do, it is ADJUDGED
and ORDERED that defendant's motion to dismiss or for
summary judgment be, and hereby is, DENIED.

Let the Clerk send a copy of this order to all counsel
of record.

/s/ Robert R. Merhige, Jr.
UNITED STATES
DISTRICT JUDGE

Date MAR 25 1988

In The

Supreme Court of the United States

October Term, 1989

GERALD L. BALILES, *et al.*,

Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,

Respondent.

On Writ Of Certiorari To The United States
Court Of Appeals For The Fourth Circuit

BRIEF OF PETITIONERS

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QUESTION PRESENTED

Whether a Medicaid provider has a private federal cause of action under 42 U.S.C. § 1983 to enforce the Medicaid Act against a state.

PARTIES TO THE PROCEEDINGS

Appellants in the Court of Appeals and defendants in the District Court are the Governor and the Secretary of Health and Human Resources of the Commonwealth, as well as the Director of the Department of Medical Assistance Services and members of the Virginia Board of Medical Assistance Services. Although the Governor and Secretary initially were sued in their individual capacities, they were dismissed in such capacities by consent of the plaintiff and by order of the District Court on May 2, 1986. They are now sued only in their official capacities.

Appellee, in the Court of Appeals and plaintiff in the District Court is the Virginia Hospital Association ("VHA"), a non-profit organization whose members include Virginia hospitals.

In the Court of Appeals, twenty-seven states filed or joined an amicus brief in support of the Commonwealth on the issue herein. The American Hospital Association filed an amicus brief in support of the VHA on the same issue. Thirty-seven states joined in an amicus brief urging this Court to hear this appeal.

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In The
Supreme Court of the United States
October Term, 1989

GERALD L. BALILES, *et al.*,

Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

**On Writ Of Certiorari To The United States
Court Of Appeals For The Fourth Circuit**

BRIEF OF PETITIONERS

On June 15, 1989, the Commonwealth of Virginia ("the Commonwealth") whose officials were Appellants below, filed a Petition for Writ of Certiorari ("the Petition") seeking review of the judgment of the United States Court of Appeals for the Fourth Circuit in this matter. On October 2, 1989, the Court granted a Writ.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fourth Circuit, dated February 22, 1989, is reported at 868 F.2d 653 and is also set forth in Appendix A to the Petition. The March 22, 1989 order of the Court of Appeals denying the Commonwealth's Petition for Rehearing and Suggestion for Rehearing *En Banc* is set forth in Appendix B to the Petition. The March 29, 1989 order of the Court of Appeals denying a stay of its mandate is set forth in Appendix C to the Petition.

The order and opinion of the United States District Court for the Eastern Division of Virginia, Richmond division, dated May 18, 1988, are unreported and are set forth in Appendix D to the Petition.

Citations herein are to the Appendices to the Petition ("App.") or the Joint Appendix ("J.A.").

JURISDICTION

The jurisdiction of this Court to issue a writ of certiorari in this case is grounded upon 28 U.S.C. § 1254(1).

STATUTES INVOLVED

VHA has brought suit pursuant to 42 U.S.C. § 1983, which states:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the

deprivation of any rights, privileges or immunities secured by the Constitution and laws shall be liable to the party injured in an action at law, suit in equity, or other proper proceedings for redress.

This appeal raises the question whether Medicaid providers may bring suit against the states in federal court under § 1983. The answer to this question turns upon the construction and application of a number of provisions of Title XIX of the Social Security Act (42 U.S.C. §§ 1396-1396t) ("the Medicaid Act"). The most important is 42 U.S.C. § 1396a(a)(13)(A), Omnibus Budget Reconciliation Act of 1981, P.L. 97-248, § 2173(a), 95 Stat. 808 ("the Boren Amendment"), which reads, in pertinent part, as follows:

A state plan for medical assistance must . . . provide . . . for payment . . . of the hospital . . . services provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services . . . and to assure that individuals eligible for medical assistance have reasonable access. . . .

42 C.F.R. §§ 447.250-447.280 sets forth the regulations implementing the Medicaid Act. The final rules implementing the Boren Amendment were published in 48 Fed. Reg. 56046-56059 (1983); See also 42 C.F.R. § 447.253(b).

STATEMENT OF THE CASE

1.

Procedural Background

On March 19, 1986, VHA filed this suit in the United States District Court for the Eastern District of Virginia challenging the validity of payment rates for hospitals participating in the Commonwealth's Medicaid program, which is administered by the Virginia Department of Medical Assistance Services ("DMAS") pursuant to Chapter 10, Title 32.1 (§§ 32.1-323-32.1-330) of the Code of Virginia. The complaint challenged the validity of the mechanism ("Prospective Payment System") used by DMAS in setting prospective *per diem* rates for inpatient hospital care of Medicaid patients, as well as the validity of the regulations prescribing procedures for the filing and processing of appeals ("Appeals System") by hospitals not satisfied with their prospective rates.

On September 22, 1986, the District Court dismissed the complaint. It ruled that VHA, being in privity with one of its member hospitals which had been a plaintiff in earlier litigation in the same court on the same subject, was collaterally estopped from bringing this action by reason of the earlier unfavorable ruling in *Mary Washington Hospital v. Fisher*, 635 F.Supp. 891 (E.D.Va. 1985).

On appeal, the Court of Appeals reversed. *Virginia Hospital Association v. Baliles*, 830 F.2d 1308 (4th Cir. 1987). It ruled that VHA, a trade association suing on behalf of its member hospitals and others, was not so estopped.

On remand, the Commonwealth moved to dismiss on eight grounds. The District Court denied the motion, but

on May 18, 1988, certified those eight issues to the Court of Appeals for interlocutory appeal. The Court of Appeals on July 27, 1988, granted that appeal. On February 22, 1989, it affirmed the ruling of the District Court, holding, *inter alia*, that the Boren Amendment confers "an enforceable right on providers" because it "guarantees reasonable and adequate reimbursement to hospitals that achieve cost-efficiency," and it does not create a "remedial scheme so comprehensive as to foreclose a private judicial remedy." (App. at A-9 to A-12). On March 22, 1989, the Court of Appeals denied the Commonwealth's Petition for Rehearing and Suggestion for Rehearing *En Banc*. On March 29, 1989, it denied a stay of its mandate pending the filing of the Petition.

This Court granted a Writ of Certiorari to consider one issue - whether a Medicaid provider has a private federal cause of action under § 1983 to enforce the Medicaid Act against a state.¹

2.

Factual Background

The Commonwealth, like all states, participates in the national Medicaid program pursuant to the Medicaid Act.

¹ This Court agreed to decide this same issue in 1987, but it did not address the merits because of changes in the underlying facts that rendered the case then under review moot. *Coos Bay Care Center v. Oregon Department of Human Resources*, 803 F.2d 1060, (9th Cir. 1986), cert. granted, 107 S.Ct. 1970 (1987), judgment vacated and remanded on the issue of mootness, 108 S.Ct. 52 (1987).

As noted above, DMAS is the agency of the Commonwealth that has been charged since 1985 with the responsibility for administering that program in Virginia. Under the program, DMAS has promulgated implementing regulations known collectively as the State Plan.

Until 1981, the Medicaid Act required states to pay participating hospitals the "reasonable cost" of inpatient services to Medicaid patients. In 1982, in response to the Boren Amendment, the Commonwealth adopted the Prospective Payment System as an amendment to the State Plan to allow the use of prospective payment for hospital services, effective July 1, 1982. (J.A. 24-45). Under the Prospective Payment System, cost medians from 1981 data were used as a starting point and an inflator, a modified Consumer Price Index ("CPI"), was used to inflate such medians to determine payment levels for subsequent years. (J.A. 12-13 and 26).

In 1983, one of VHA's member hospitals brought a challenge to the Prospective Payment System. *Mary Washington Hospital, supra*. On January 4, 1985, the District Court in *Mary Washington* - the same District Court as in this case - upheld the legality of the Prospective Payment System in its entirety, except for its distinct appeals mechanism, but ordered the Commonwealth to promulgate a new appeals mechanism. The new Appeals System was adopted by DMAS in August 1985, and approved by the federal Health Care Financing Administration ("HCFA") on March 3, 1986. (See J.A. 32-45). The District Court upheld the legality of the Appeals System by order dated April 21, 1986. No appeal was filed.

With the exception of three replacements of the CPI with different inflators and other minor changes not relevant to this litigation, the Prospective Payment System remains unchanged since its original promulgation in 1982. The Appeals System has not been amended at all since its 1985 promulgation. None of the almost 100 member hospitals of VHA represented in this litigation has pursued an appeal under the Appeals System, although they have preserved their right to do so.²

SUMMARY OF ARGUMENT

The intent of Congress is the key to determining whether hospital providers have an implied right of action under § 1983 to enforce the Boren Amendment against the states in federal court. *Merrill Lynch, Pierce, Fenner & Smith v. Curran*, 456 U.S. 353, 377, (1982); *Middlesex County Sewerage Auth'y v. National Sea Clammers Ass'n*, 453 U.S. 1, 13 (1981). See also *Cannon v. University of Chicago*, 441 U.S. 677, 740 (1979) (Powell, J. dissenting). Whether judged under the "benefited class" analysis, first set forth in *Cort v. Ash*, 422 U.S. 66 (1975) and modified by *Cannon, supra*, and *Merrill Lynch, supra*, or the

² The lower courts have ruled that VHA has standing to bring this action on behalf of its members (App. at A-14), even though it is not a hospital or a Medicaid provider and has no direct or proprietary interest in its members' reimbursement. 830 F.2d at 1312-13.

"enforceable rights" analysis of *Maine v. Thiboutot*, 448 U.S. 1 (1980) and its progeny, the fundamental question in determining congressional intent is the same: at the time the Boren Amendment passed in 1981, did Congress know that its failure to provide an express right of action for providers would be construed to mean that a federal cause of action to enforce the Boren Amendment would be implied under § 1983? *Merrill Lynch*, 456 U.S. at 378-79.

Several factors are relevant in deciding the answer to this question. The first is whether the language of the Boren Amendment is "right- or duty-creating language" that "explicitly conferred a right directly on a class of persons" including hospital providers of medical services to Medicaid-eligible patients. *Cannon*, 441 U.S. at 690, n.13. The Boren Amendment explicitly imposed on the states general standards to be met in establishing new prospective payment systems designed to control Medicaid costs while assuring the continued availability of medical services for the needy. The language of the Boren Amendment, however, does not reveal an "unmistakable focus" on providers as the "benefited class." *Cannon*, 441 U.S. at 691. It does not create an enforceable right by affirmatively granting providers a "right" to any level of payment if they contract to provide services under the Medicaid program.

The second factor in determining Congressional intent is whether an implied right of action for providers under § 1983 was a part of the "contemporary legal context" of 1981 when Congress passed the Boren

Amendment. See *Merrill Lynch*, 456 U.S. at 381. At the time Congress adopted the Boren Amendment, both the general implied right and § 1983 lines of cases had evolved from the early reflexive analysis that almost always assumed the existence of implied federal rights of action, see, e.g., *Texas & Pacific R. Co. v. Rigsby*, 242 U.S. 33 (1916), to the more considered calculus of *Cort*, *supra*, *Cannon*, *supra* and *Sea Clammers*, *supra*. Congress is assumed to have had knowledge of these developments when it acted. *Cannon*, 441 U.S. at 696-97. Thus, its failure to grant providers an explicit right of action to enforce the Boren Amendment weighs heavily against the implication of private rights by the Court.

Moreover, the elaborate federal/state partnership embodied in the Medicaid Act evidences Congressional intent to foreclose, rather than to grant, federal causes of action by providers against the states. Under the Medicaid Act, the states have extensive administrative responsibility for the operation of the program. The program, as developed, reflects an elaborate series of checks and balances designed to assure the delivery of necessary medical services to the needy, while leaving the states flexibility in designing payment systems and giving the federal government sufficient control to assure fiscal accountability. The comprehensiveness of the scheme, the existence of federally mandated state administrative appeals procedures and the adoption and repeal of a required waiver of the states' Eleventh Amendment immunity, all confirm Congress' intent to limit provider payment challenges to state administrative procedures and appropriate judicial review by state courts.

The validity of this reading of Congressional intent is confirmed by the administrative interpretation of the Boren Amendment reflected in regulations adopted contemporaneously by the federal official charged with the responsibility to administer the Medicaid program, 48 Fed. Reg. 56046, 56052 (1983). The Secretary of Health and Human Services explicitly declined to adopt regulations requiring the states to permit providers to challenge payment decisions in judicial forums. The Secretary determined that such challenges should be reviewed in state administrative proceedings, not federal courts. This interpretation should be accorded "considerable weight" by this Court in deciding the implied rights question. *Chevron, USA, Inc. v. National Resources Defense Council, Inc.*, 467 U.S. 837 (1984).

ARGUMENT

I.

CONGRESS DID NOT INTEND HOSPITAL PROVIDERS TO HAVE AN IMPLIED CAUSE OF ACTION TO ENFORCE THE MEDICAID ACT UNDER § 1983

Two lines of cases leading to implied private rights of action increasingly are merged in the opinions of this Court. The first line of cases, governing the general question whether a federal statute includes a private right of action, extends over several generations from *Rigsby, supra* through *Cort, supra* and *Merrill Lynch, supra*. The historical evolution of this line of cases, summarized in

Merrill Lynch, 456 U.S. at 374-377, demonstrates that this Court no longer will imply a private cause of action solely from the fact that a particular federal statute was enacted for the benefit of a special class, as the Court did in *Rigsby, supra*. Rather than assume a judicial remedy for the benefited class from Congressional silence or ambiguity, the Court now focuses specifically on the question whether Congress *intended* to create a private *remedy* for the benefited class. *Merrill Lynch*, 456 U.S. at 378-79.

Similarly, the implied right of action cases under § 1983 increasingly look to legislative intent to create a cause of action as the dispositive factor in determining whether § 1983 is available to enforce a violation of a federal statute against a state. Thus, even where a federal statute is intended to benefit a defined class of persons or entities, unless Congress also intended to create "enforceable rights" for that defined class, no cause of action under § 1983 can be implied. *Wright v. Roanoke Redevelopment & Housing Auth'y*, 479 U.S. 418, 423 (1987). Moreover, even where such enforceable rights are express or implied, the existence of a comprehensive alternative enforcement scheme to vindicate those rights will be read as evidence of a Congressional intent to foreclose an implied right of action under § 1983. *Sea Clammers*, 453 U.S. at 19-20.

Accordingly, no private cause of action on behalf of hospital providers should be implied under § 1983 in this case unless this Court determines that Congress specifically *intended* hospital providers to be able to pursue

payment disputes under the Medicaid program directly in federal court.³ Congressional intent to create such a cause of action should not be implied based on the nature of the Medicaid program or the status of providers, but rather should be found, if at all, only in explicit rights-granting language not accompanied by the existence of an alternative enforcement mechanism.⁴

A. The Language of the Boren Amendment to the Medicaid Act Does Not Confer "Enforceable Rights" on Hospital Providers.

The language of the Boren Amendment cannot fairly be read to create rights or duties. Section 1396a(a)(13)(A)

³ Neither VHA nor the lower courts have even suggested that the Medicaid Act creates an express right enforceable by a Medicaid provider against a state. (App. at A-5). The statute is silent, a fact which, when combined with a correct analysis of its actual language, of its purpose and of its legislative history, leads to the inescapable conclusion that Congress did not simply overlook the issue. It made deliberate choices about how the Medicaid program should work.

⁴ As this Court most recently recognized in *Dellmuth v. Muth*, ___ U.S. ___, 109 S.Ct. 2397 (1989) and *Will v. Michigan*, ___ U.S. ___, 109 S.Ct. 2304 (1989), courts should not attempt to imply the fundamental realignment of powers allocated to the state and federal systems without a clear expression of congressional intent, manifest in the statute under review. To allow providers to challenge state reimbursement systems in federal court would have just such an effect, without any indication of Congress' intent to provide a federal cause of action. Furthermore, such a result would promote none of the goals normally inherent in federal litigation over federal statutes as each state's reimbursement system is unique and tailored to the special health care cost conditions in the particular state.

merely authorizes the states to devise payment rates which *the state finds, and makes assurances satisfactory to the Secretary*, are "reasonable and adequate" to meet the cost which "must be incurred by efficiently and economically operated facilities" to provide patient care. The statute allows the rates to be set in accordance with methods and standards developed by each state, reviewable only by HCFA.

This broad standard of "reasonable and adequate" is not the kind of language Congress has used to create an enforceable right. It does not read like a statute designed to "dictate specifically what the relevant government officials may and may not do." *Edwards v. District of Columbia*, 821 F.2d 651, 656 (D.C.Cir. 1987). Rather than "right-or duty-creating language," *Cannon*, 441 U.S. at 690 n.13, the relevant language in the Medicaid Act is very much analogous to that examined by this Court in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), and it is quite different from the specific and objective standards found to exist in *Wright, supra*.⁵

⁵ The Court of Appeals acknowledged (App. at A-6, n.3) that the Medicaid Act was enacted under the spending power of Article I, Section 8, clause 1 of the United States Constitution. The Court in *Pennhurst* likened such legislation to a contract. In this case, the contracting parties are the federal and state governments. "The legitimacy of Congress' power to legislate under the spending power . . . rests on whether the State voluntarily and knowingly accepts the terms of the 'contract' There can, of course, be no knowing acceptance if a state is unaware of the conditions or is unable to ascertain what is expected of it." 451 U.S. at 17. (Citations omitted). The Court of Appeals, nevertheless, proceeded unilaterally to rewrite that contract to the detriment of the states.

In *Pennhurst*, an action was brought under the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. §§ 6000-6081, *et seq.*, to challenge conditions at a state facility for the mentally retarded. One part of the statute, § 6010, the "bill-of-rights" provision relied on by the plaintiffs, set out a series of findings respecting the rights of persons with developmental disabilities. Plaintiffs also alleged a violation of § 6011 which required participating states, as a condition of receiving federal funds, to make "assurances" to the Secretary about their plans for retarded citizens.

This Court held that § 6010 does not create substantive rights and does no more than express a Congressional preference for certain kinds of treatment. 451 U.S. at 11, 19. It found the statutory language precatory, not mandatory. On the section governing "assurances," the Court stated that "[i]t is at least an open question whether an individual's interest in having a state provide these 'assurances' is a 'right secured' by the laws of the United States within the meaning of § 1983." 451 U.S. at 28.

In *Wright*, tenants in a federally funded housing project sued to enjoin violations of a rent ceiling imposed by the Brooke Amendment to the Housing Act of 1937, P.L. 91-152, § 213, 83 Stat. 389. There the Court found that the statute "could not be clearer" in setting a mandatory and numerically specific limitation on rents. 479 U.S. at 430. The Court reviewed the statute and implementing HUD regulations and determined that the benefits Congress intended to confer on *tenants* are sufficiently specific and definite to qualify as enforceable under § 1983. 479 U.S. at 432.

The Boren Amendment obviously enunciates a policy goal or choice of Congress, reviewable by HCFA, but leaves the states considerable flexibility in the achievement of that goal. That being so, it is not the kind of statute that imposes – beyond the submission of assurances to HCFA – an affirmative obligation, *Polchowski v. Gorris*, 714 F.2d 749, 751 (7th Cir. 1983), or is "cast in the imperative." *Alexander v. Polk*, 750 F.2d 250, 259 (3d Cir. 1984).

The lower courts in this case have ruled that hospitals are among the intended beneficiaries of the Medicaid program, a national joint federal/state welfare program designed to pay medical expenses for the eligible poor, and therefore, that they have "enforceable rights" under the Boren Amendment. For a rationale, the Court of Appeals merely looked at a large number of provisions of the Medicaid Act (App. at A-7) which spell out what a state plan must contain. Because that statute – one of the most complex in existence⁶ – gives detailed instructions to the federal Secretary (HCFA) regarding conditions for continued approval of state plans, the Court of Appeals made the conclusory and wholly unsupported assumption that these conditions are all necessarily enforceable by providers under § 1983.⁷ In so doing, the Court of

⁶ This Court has called the Medicaid Act "Byzantine." See, *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981).

⁷ While two other circuits have followed the lead of the Court of Appeals in this case, federal courts are far from unanimous on the correct resolution of the issue of implied provider rights now before this Court. Compare *West Virginia University Hospitals, Inc. v. Casey*, No. 89-5165 (3d Cir. September 5, 1989) and *Amisub (PSL), Inc. v. Colorado Department of*

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Appeals equated the receipt of some financial benefit from participation in the Medicaid program with an enforceable right to a particular level of payment. One does not follow from the other.*

Moreover, the equation drawn by the Court of Appeals ignores the purpose of the statutes involved and misapplies *Pennhurst* and *Wright*. The elaborate statutory requirements of the Medicaid Act are nothing more than

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Social Services, 879 F.2d 789 (10th Cir. 1989), (accepting the Fourth Circuit's reasoning) with *Silver v. Baggiano*, 804 F.2d 1211, 1216 n.3 (11th Cir. 1986); *Green v. Cashman*, 605 F.2d 945 (6th Cir. 1979); and *Case v. Weinberger*, 523 F.2d 602 (2d Cir. 1975) (health care provider is not the intended beneficiary of the Medicaid program). The Tenth Circuit's pre-Amisub decisions conflict. Compare *Colorado Health Care Ass'n v. Colorado Department of Social Services*, 842 F.2d 1158 (10th Cir. 1988) with *Geriatrics, Inc. v. Harris*, 640 F.2d 262 (10th Cir. 1981), cert. den. 454 U.S. 832 (1981). See generally *Cervoni v. Secretary of Health, Education and Welfare*, 581 F.2d 1010 (1st Cir. 1978) (holding that a physician is not the intended beneficiary of the Medicare program).

* *Pennhurst* holds that a statute may benefit a class without being directly enforceable by those beneficiaries. By glossing over the difference between providers and recipients and by assuming providers are intended beneficiaries of the Medicaid Act, the Court of Appeals concluded that there must, of necessity, be private § 1983 enforcement. As a result, it performed no principled analysis as to whether providers truly are the intended beneficiaries and whether increased reimbursement for providers would necessarily and directly result in improved access to or quality of health care for recipients. Because there are competing interests at stake, this approach was not sufficient.

a checklist of grant conditions.⁹ Each represents a Congressional instruction for HCFA to use in reviewing state plans. In fact, each change in state plan requirements generates a response from HCFA in the form of revised instructions to the participating states. HCFA has even developed an instruction manual for the states and a large number of "pre-printed" pages to be checked off and included in state plans. Failure to comply can, and sometimes does, result in disallowance of federal funding. Such disputes, because they involve a federal agency, are necessarily resolved through federal administrative and judicial review. There is not the slightest indication, however, that Congress intended the burgeoning provisions of the Medicaid Act to be enforceable privately against states by Medicaid providers in federal court.

B. No Intent to Create an Implied Right of Action Can Be Inferred from the Legislative History of the Boren Amendment or the Medicaid Act.

The original and sole continuing purpose of the Medicaid Act is to create a program which is designed to pay

⁹ Participation in the Medicaid program is voluntary, except as to those providers who have contracted to participate for other reasons, such as the valuable consideration received under the Hill-Burton program. 42 U.S.C. §§ 291-291o-1. Thus, a provider has a right to reimbursement as provided by the mutual obligations of a contract with its respective state. Such contracts, voluntarily renewed on a regular basis, obligate the providers to accept as payment in full the payments provided pursuant to the state regulations challenged by the VHA in this litigation.

for medical care for the eligible poor.¹⁰ Nothing in the legislative history of the Act contains even a suggestion that Congress intended providers to be its beneficiaries or to have privately enforceable rights.¹¹ To the contrary, the legislative record shows conclusively that the growing and increasingly complex provisions of the Medicaid Act – and in particular the Boren Amendment – are designed to guide HCFA in its continuous oversight and review of state plans and programs.

A correct reading of the Boren Amendment and the underlying regulations, 42 C.F.R. §§ 447.250-447.280, demonstrates that Congress intended the various states' implementing programs to be policed and reviewed by the Secretary, not through a myriad of private actions in federal courts. The Medicaid Act was intended to require the participating states to provide assurances to the

¹⁰ The purpose of the Medicaid Act is:

For the purpose of enabling each State as far as practicable under the conditions in such State to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care

42 U.S.C. § 1396.

¹¹ See generally S.Rep. No. 404, 89th Cong., 1st Sess., reprinted in 1965 U.S. Code Cong. & Admin. News 1943.

Secretary of the reasonableness of payment rates and to obtain the Secretary's approval as a pre-condition to federal funding.

From 1972 until 1981, Congress had required "reasonable cost" reimbursement to be paid by the states to hospital and nursing home providers, thus linking such reimbursement to those facilities' actual costs in a way designed to assure that payment would reflect the costs necessary to provide service of adequate quality. See S. Rep. 96-471, 96th Cong., 1st Sess. 28 (1979). Under "reasonable cost" reimbursement, providers had been able to recover essentially all of their allowable costs incurred in providing care or services to Medicaid patients.

In 1981, Congress abandoned the "reasonable cost" formula by enacting the Boren Amendment.¹² In so doing, Congress made clear that its action represented a significant change in the federal standard, offering the states an opportunity to effect more stringent cost containment while freeing them from excessive oversight of their payment methodologies. *Wisconsin Hospital Ass'n v. Reivitz*, 733 F.2d 1226, 1228 (7th Cir. 1984). See also *Mary Washington*, *supra*, 635 F. Supp. at 894, 899. This

¹² In 1981, Congress adopted for hospitals the principle it had adopted a year earlier for nursing home providers. The Boren Amendment was drawn from a bill previously reported by the Senate Finance Committee. See 126 Cong. Rec. 17885-17886. Explaining that bill, Senator Boren, its patron, stated: "[P]ayment methods adopted by the States will carry a presumption of compliance." *Ibid.* The legislative purpose was designed both to remove the prior cost-based reimbursement formula and to reduce excessive federal oversight of provider payment methodologies.

change was designed to give states greater flexibility in attempting to promote efficiency in hospital services and to contain soaring Medicaid costs. *Id.* at 894. *Accord, Mississippi Hospital Ass'n, Inc. v. Heckler,* 701 F.2d 511, 521 (5th Cir. 1983).¹³

Congress made a deliberate decision to give the states this flexibility. Such a dramatic change, rejecting expensive cost-based reimbursement and encouraging both state creativity and a wider range of choices for the states, indicates a clear legislative choice to allow state-specific latitude in determining appropriate methodologies for payments to providers. Congress intended nothing more than to provide legislative guidance to HCFA in evaluating state plans. S. Rep. No. 139, 97th Cong., 2d Sess., reprinted in 1981 U.S. Code Cong. & Admin. News 744. No objective standards were set or required. Congress stated that it "did not intend to encourage arbitrary reductions" in rates which would adversely affect patient care; it indicated simply that rates must be "related to" providers' reasonable costs. The Committee report itself refers to these statements as "goals." *Id.* (App. at A-9). Under the *Pennhurst* test, "goals" are not "enforceable rights."

¹³ The legislative history of the Boren Amendment indicates that:

[i]n eliminating the current requirement that States pay hospitals on a Medicare "reasonable cost" basis for inpatient services under Medicaid, the Committee recognizes the *inflationary nature* of the current cost reimbursement system and intends to give States *greater latitude* in developing and implementing alternative reimbursement methodologies that promote the efficient and economical delivery of such services.

H.R. Rep. No. 158, 97th Cong. 1st Sess. 293 (1983) (emphasis added).

If more proof of Congressional intent were needed, over a decade ago and before the adoption of the Boren Amendment, Congress mandated and, within a year thereafter, repealed a requirement that, as a condition of continued participation in the Medicaid program, states waive their Eleventh Amendment immunity from suits by hospitals over reimbursement. That is the exact subject of this litigation. What is particularly instructive, however, is that Congress *expressly rejected* federal litigation over this subject and at the same time - concerned that providers would not have a forum in which to raise reimbursement issues - directed HCFA to develop a mechanism for the adjudication of such disputes. S. Rep. No. 1240, 94th Cong., 2nd Sess., reprinted in 1976 U.S. Code Cong. & Admin. News 5648, 5649-51. What resulted is the present regulation requiring state appeals procedures such as the Commonwealth's Appeals System. See 42 C.F.R. § 447.253(c).

C. No Intent to Create an Implied Right of Action Can Be Inferred from the "Contemporary Legal Context" in Which Congress Acted When It Adopted the Boren Amendment.

This Court held in *Merrill Lynch*, 456 U.S. 353, 378 (1982), that

[i]n determining whether a private cause of action is implicit in a federal statutory scheme when the statute is silent on that issue, the initial focus must be on the state of the law at the time the legislation was enacted.

Congress is presumed to have been familiar with judicial decisions implying private rights of action as they existed at the time the Boren Amendment was adopted in 1981. *Cannon*, 441 U.S. at 696-697.

At that time, the law of private rights of action had evolved to the point that it was clear explicit "rights-granting" language was necessary to imply a private cause of action for providers under either the Medicaid Act itself, *Cannon*, 441 U.S. at 690-692, or § 1983, *Maine v. Thiboutot*, 448 U.S. 1 (1980). Congress is presumed to know that fact. *Cannon*, 441 U.S. at 696-697. Moreover, Congress is presumed to have known that the existence in the statute and regulations of a comprehensive enforcement scheme would be construed as evidence of Congressional intent to foreclose private enforcement of the Medicaid Act under § 1983. See *Clammers*, 453 U.S. at 20; *Pennhurst*, 451 U.S. at 28.

In this context, the failure of Congress either to grant providers an explicit cause of action or to use language explicitly vesting providers with a right to reimbursement under the Medicaid Act¹⁴ means that Congress did not intend for providers to bring suit in federal court under § 1983 to enforce the terms of the Boren Amendment.

D. The Medicaid Program Is a Complex Federal/State Partnership, Reflecting Decades of Difficult Legislative and Political Compromises and Including Federally Mandated Appeals Procedures, from Which a Congressional Intent to Foreclose a Federal Cause of Action Can Be Implied.

In the present case, the Court of Appeals found that the Commonwealth had not met its burden of showing an

¹⁴ Unlike the statute at issue in *Cannon*, Title IX of the Education Amendments of 1972, 20 U.S.C. § 1681, which

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implied intent to foreclose. (App. at A-11). Despite an assumption (which is correct) that HCFA vigorously enforces the Medicaid Act, and despite evidence that, unlike the regulations in *Wright*, the federal agency's interpretation is consistent with that of the Commonwealth, the Court of Appeals retreated from its own prior decision on foreclosure in *Phelps v. Housing Authority of Woodruff*, 742 F.2d 816, 821 (4th Cir. 1984). It simultaneously recognized and discounted the fact that the Commonwealth, as required by federal regulation, has established a comprehensive administrative Appeals System.¹⁵ In ruling as it did, the Court of Appeals turned the Medicaid program on its head.¹⁶

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provides that "no person" shall be discriminated against in any federally assisted program, the Boren Amendment provided only that a "state plan must . . . provide . . . for payment. . ." See page 3 *supra*.

¹⁵ This system also includes state judicial review in accordance with § 32.1-325.1 of the Code of Virginia and pursuant to the Virginia Administrative Process Act, §§ 9-6.14:1-9-6.14:25 of the Code of Virginia.

¹⁶ The Court of Appeals apparently (App. at A-11) found the lack of a judicial remedy in the statute controlling. But *Wright* does not establish the lack of such a provision as the *sine qua non* for legislative foreclosure. Indeed, the *Wright* majority based its decision on what it found to be a clear, mandatory, objective limitation on rental payments in the statute. It also found the intent to benefit tenants "undeniable." 479 U.S. at 430. Compare the dissenting opinion of Justice O'Connor in which she stated that the statutory entitlement found by the majority arose not from the statute or the legislative history but from a regulatory interpretation. 479 U.S. at 434-435.

Medicaid is a unique joint federal/state partnership, one in which the states have extensive administrative responsibility. Over the years, a series of choices and decisions have been made in its development. These have been hammered out in the political, not the judicial arena, and have been accepted by the states and the federal government as workable. As noted above, the Boren Amendment was expressly designed to allow flexible state payment policies and decisions, reviewable only by HCFA against the growing patchwork of federal legislative and regulatory guidelines. At the same time, HCFA has protected the federal interests expressed in the Medicaid Act through a comprehensive program of ongoing state plan reviews, audits and - where appropriate - adjustments or disallowances sufficient to ensure accountability for federal funds.¹⁷

Ironically, in relying in their analyses on Congressional efforts to reduce federal oversight of state payment methodologies and decisions, the Court of Appeals and the District Court have thwarted and reversed that objective by grafting federal judicial review onto the program. The result is confusing, wasteful of resources and duplicative. To assume that Congress intended such a

course is unwarranted and illogical. The States that urged this Court to review this case never foresaw a Medicaid program with the potential for multiple and endless litigation of provider payment issues in both federal and state courts. They did not bargain for the expense, the delay, or the need for legal and administrative resources that such litigation entails. Nor did they anticipate that their federally-mandated, carefully-constructed and federally-approved administrative appeals systems would be rendered redundant by providers' decisions to seek *de novo* adjudication of payment disputes in the federal courts.

The lower courts have undone the delicate and sometimes difficult compromises reached through the continuing political process and have forced the states to defend their policy choices repeatedly in federal court.¹⁸

In so doing, the lower courts have diverted increasingly scarce resources, both federal and state, from

¹⁷ This oversight is more direct, more intense and doubtless more effective than the casually-exercised HUD powers found in *Wright* to be insufficient to indicate legislative foreclosure of § 1983 remedies. 479 U.S. at 428.

¹⁸ The history of the present case provides just such an example. As soon as the Mary Washington Hospital's unsuccessful challenge to the Commonwealth's reimbursement system in federal court was complete, the VHA filed the present action in the same federal court. While this case was pending, the Commonwealth was forced to, and successfully did, defend *Vantage Healthcare Corp. v. Virginia Board of Medical Assistance Services*, 684 F.Supp. 1329 (E.D.Va. 1988) (holding that a nursing home provider could not challenge under § 1983 the elimination of an incentive payment). Pennsylvania has similarly been plagued by repeated challenges to various aspects of its Medicaid reimbursement system in federal court. At present, Pennsylvania is defending five separate reimbursement challenges brought at the first instance in federal district court. See Appendix B of the Amicus Brief submitted by thirty-seven states in support of the petition.

medical care for the poor to the defense of litigation. This weakens this vital national program which, although increasingly costly, is a mainstay of the welfare "safety net" designed to assist our poorest citizens, including a large number of children and the elderly.

The Court should not allow the lower courts' decisions to stand. If Congress had wished to foster repetitive, unnecessary and expensive litigation of this type, it could and should have done so in unmistakably clear language.¹⁹ It did not, and this Court should not fill that legislative role by allowing providers to subvert the long-standing political process which has developed into the present Medicaid program.²⁰ Taken as a whole, the Medicaid Act and the implementing regulations are sufficiently comprehensive in scope to support a finding that Congress intended to foreclose alternative remedies.

¹⁹ In his dissent in *Cannon*, 441 U.S. at 749, Justice Powell suggested that requiring such clarity from Congress would "encourage Congress to confront its obligation to resolve crucial policy questions created by the legislation it enacts."

²⁰ The Court of Appeals suggests that Congress would not have required hospitals to participate in the Hill-Burton program but "implicitly deny" these same hospitals "an enforceable right to reimbursement rates that meet their costs." App. A-10 n.6. To the contrary, this is exactly what Congress intended when it passed the Boren Amendment repealing required cost-based reimbursement and permitting states to adopt prospective payment plans designed to control costs by forcing hospitals to operate economically and efficiently.

II.

THE SECRETARY HAS DETERMINED THAT THE MEDICAID ACT DOES NOT REQUIRE DIRECT JUDICIAL ENFORCEMENT OF PAYMENT DISPUTES AND THIS INTERPRETATION IS ENTITLED TO DEFERENCE.

The agency charged with enforcing the Medicaid Act has determined that state provider payment decisions are best reviewed in state proceedings and that jurisdiction for such review lies exclusively in state forums. In specifically implementing the Boren Amendment in 1981, HCFA published interim regulations that ultimately became final in December of 1983. See 46 Fed. Reg. 47964 (1981) and 48 Fed. Reg. 56046 (1983). In the latter, HCFA set out a preamble which, *inter alia*, rejected public comments suggesting that judicial review of payment rates should be provided:

[A]bsent any statutory mandate, there is no Federal authority to require judicial recourse (presumably in State courts) for providers dissatisfied with State payment rates. Of course, under both the current and revised regulations, providers are free to pursue whatever judicial remedies are available *in their States* after they have exhausted the administrative appeal process.

48 Fed. Reg. 56046, 56052 (1983) (emphasis added).

As this Court has recognized, at the very least, "considerable weight" should be accorded this administrative interpretation. See *Chevron*, 467 U.S. at 844. Indeed, in a statutory scheme as complex as the Medicaid Act, the Secretary's interpretation, based on longstanding expertise and explicit Congressional delegation, S. Rep. No.

1240, 94th Cong. 2d Sess., reprinted in 1976 U.S. Code & Admin. News 5648, 5649-51, should be given "legislative effect," and review of that interpretation by the courts should be limited to ensuring that the Secretary did not exceed his statutory authority and that the regulation is not arbitrary or capricious. *Schweiker*, 453 U.S. at 43.

Clearly, the Secretary's decision to require providers to challenge state provider payment decisions in state administrative proceedings must be given great deference, and this Court should not disturb the Secretary's longstanding interpretation of the Medicaid Act as it relates to the review of state provider payment decisions.

CONCLUSION

The lower courts have created, by implication from the Medicaid Act, enforceable rights for Medicaid providers. By allowing these rights to be enforced privately under § 1983 in a federal forum, the courts have restructured the national Medicaid program and disregarded Congressional intent that *states* devise individually-tailored reasonable payment plans rather than follow any express, mandatory system created by the Medicaid Act.

Congress deliberately did not create a specific enforceable right to any defineable level of payment on behalf of health care providers. The language and legislative history of the Medicaid Act clearly indicate that Congress intended two checks on state provider payment plans - review and approval by the Secretary and a state appeal process - but not federal, judicial interference.

To permit such judicial interference will upset the efficiency and workability of the system devised by Congress and ignore the fact that Congress struck a special balance between federal and state enforcement in creating and maintaining the unique Medicaid Program. The decisions of the courts below have upset and altered that balance. The Secretary's interpretation of program requirements reflecting this balance is entitled to deference.

For all of the reasons stated, the Commonwealth respectfully requests the Court to reverse the ruling of the Court of Appeals.

Respectfully Submitted,

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of the United States

1969

ALLIES, et al.,

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ETAL ASSOCIATION,

Respondent.

United States
Court of Appeals
for the Circuit

Jr.

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QUESTION PRESENTED

Whether a Medicaid provider has a cause of action under 42 U.S.C. § 1983 to enforce compliance with the provider reimbursement requirements of 42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. V 1987).

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IN THE

Supreme Court of the United States

October Term, 1989

NO. 88-2043

GERALD L. BALILES, *et al.*,

Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,

Respondent.

*On Writ of Certiorari to the United States
Court of Appeals For the Fourth Circuit*

BRIEF OF RESPONDENT

STATUTES AND REGULATIONS INVOLVED

The text of relevant statutes and regulations is set forth in the appendix to this brief.

STATEMENT OF THE CASE

In March 1986, respondent Virginia Hospital Association ("VHA") filed this action in federal district court against the petitioners, officials of the Commonwealth of Virginia sued in their official capacities ("defendants"), seeking declaratory and injunctive relief for violations of federal rights secured by Title XIX of the Social Security Act (the "Medicaid Act") regarding reimbursement of its member hospitals under the Virginia State Medicaid Plan ("state plan"). J.A. 3-4.

The state plan was amended effective July 1, 1982, creating a prospective reimbursement system for hospitals which established per diem reimbursement ceiling rates for peer groups of hospitals. The ceiling rates were based on the average cost per day of the median hospital in each peer group based on hospital cost reports for the year 1981, inflated to July 1, 1982. The ceilings were then set by increasing the medians by a reimbursement escalator. J.A. 16. A hospital's payments were set at the lower of its last fiscal year's average cost per day, adjusted by the escalator, or the hospital's peer group ceiling. Since 1982, the peer group ceilings have been adjusted periodically only through application of the reimbursement escalator based on a simple inflation index. The original medians have never been recomputed using more recent actual cost data. J.A. 12-13.

The VHA alleges that the reimbursement methodology adopted under the state plan has not escalated ceilings for all periods of inflation incurred and does not take into account a number of critical factors that cause hospital costs per day to rise at a rate higher than inflation. These factors include changes in technology; changes in care practices by physicians and hospitals; availability of nurses; treatment of more patients, both medical and surgical, in outpatient departments; decreases in average lengths of stay per hospital admission; and the increasing intensity of the inpatient services rendered per patient day. J.A. 14-15.

Despite implementing cost-saving measures which saved Virginia \$19.8 million in 1986 alone, J.A. 50, and despite the fact that Virginia hospitals are low-cost health care providers based on a nationwide comparison of costs, J.A. 16, no hospital in Virginia is currently paid at a rate which meets its efficiently and economically incurred costs in providing services to Medicaid recipients. ¶ 10, Affidavit of

Mr. Rueben attached as Exhibit A to Respondent's Memorandum in Opposition to Application For Stay of Proceedings in the District Court Pending Disposition of Appeal, filed with this Court on October 23, 1989, by request of the Court.)

The VHA alleges that enforcement of the state plan violates its members' federal rights to reasonable and adequate reimbursement as a result of fundamental, systemic flaws in the methodology of the state plan. This suit is not about claims disputes; nor is it about individual hospitals objecting to the manner in which the state's reimbursement plan is applied to them. The VHA seeks prospective relief from the defendants' enforcement of a state plan which violates the hospital reimbursement requirements of the Medicaid Act.

SUMMARY OF ARGUMENT

For the past twenty years, hospitals that treat Medicaid patients have been accorded the right to sue state officials in federal court under 42 U.S.C. § 1983 (1982) to remedy state violations of the Medicaid Act's provider reimbursement standards, 42 U.S.C. § 1396a (a)(13)(A) (1982 & Supp V 1987). Congress has repeatedly acknowledged its awareness and approval of a Medicaid provider right to maintain such actions in federal court. Nevertheless, the defendants ask this Court now to revoke this right to sue by holding either that Congress never created a federal right, or that Congress intended to preempt the remedy under § 1983 by creating an alternative, comprehensive remedial scheme. The court of appeals below properly rejected both of these arguments.

In *Maine v. Thiboutot*, 448 U.S. 1 (1980), this Court confirmed what many federal courts had previously held (and what this Court had itself previously assumed)—that in enacting § 1983, Congress provided a cause of action to

redress the deprivation by state officials of "any right" secured by "the laws" of the United States. The holdings in *Thiboutot* and the line of § 1983 cases which followed it were reaffirmed less than a month ago in *Golden State Transit Corp. v. City of Los Angeles*, No. 88-840 (U.S. Dec. 5, 1989). Judged by the standards reiterated in *Golden State*, providers of Medicaid services clearly have an enforceable federal right to be reimbursed under a state plan that meets the federal provider reimbursement standard. This statutory requirement is not a mere expression of congressional preference, but rather, as Congress itself has consistently recognized, a legal obligation binding on those states which choose to participate in the Medicaid program. Under the language of the statutory provision, which is cast in mandatory, not precatory terms, "a state plan for medical assistance must provide for payment of the hospital . . . services." The provision in question was clearly intended to benefit hospitals, which are expressly identified as entities to whom payment is directly due.

The provision's central requirement—that a state plan must be designed to provide for reimbursement rates that are "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities"—is a standard whose enforcement has proven in practice to be wholly within the competence of the judiciary. The right of providers to have their costs reimbursed under a state plan that meets the minimum federal provider reimbursement standard is a right secured by the laws of the United States.

It is equally clear that the defendants have failed to discharge their burden of demonstrating that Congress created a comprehensive, alternative remedial scheme intended to supplant the § 1983 remedy. Congress has significantly reduced federal administrative oversight and has required the creation of a state appeals or exception process only for resolution of payment of individual claims

disputes. Furthermore, it has provided for no substitute private cause of action. No alternative forum exists for adjudication of a systemic challenge to the reimbursement principles of a state's Medicaid plan.

The legislative history and the overall purpose of the Medicaid provider payment standards clearly reveal Congress's intent to vest a federally secured right in providers and to preserve for them a § 1983 cause of action to protect that right. Each of the congressional revisions of the payment standards was enacted against a background of federal judicial protection of provider payment rights stretching back at least to 1969. Both the existence of a right and its enforceability in federal court were expressly acknowledged by Congress and the Secretary during consideration and enactment of legislation in 1976 which restored the states' eleventh amendment immunity from actions for damages, but which, it was expressly stated, did not affect provider suits for injunctive relief.

Congress's preservation of providers' substantive right and of their § 1983 cause of action plays an essential role in the overall Medicaid scheme. Congress has always recognized the close connection between adequate provider compensation and the success of Medicaid in affording medical care to those in need. Without a cause of action under § 1983, providers would have no effective means of raising the question of state compliance with the requirements of the Act.

ARGUMENT

I.

THE HISTORY OF THE MEDICAID LEGISLATION DEMONSTRATES THAT CONGRESS INTENDED TO AFFORD FLEXIBILITY TO THE STATES BY REDUCING FEDERAL ADMINISTRATIVE OVERSIGHT, WHILE RETAINING ACCESS TO FEDERAL COURT TO ENFORCE RIGHTS SECURED BY 42 U.S.C. § 1396a(a)(13)(A)

The history of Medicaid legislation demonstrates that since the inception of the Act in 1965 Congress has maintained a careful balance between ensuring that participating states provide for adequate funding for Medicaid services and encouraging the goals of efficiency and cost control. On a variety of occasions since 1965 Congress has returned to the Act with the intent of adjusting this balance; at no point in its frequent dealings with Medicaid, however, has Congress repudiated its original purpose of requiring states to comply with the fundamental federal standards governing their Medicaid plans. In addition, Congress has been careful to preserve for providers a cause of action for prospective relief as an essential remedy to protect their right to payment in accordance with the Act.

1. Section 1902(a)(13)(B) of the 1965 Act, Pub. L. No. 89-97, contained a specific provision addressing payment to hospitals for Medicaid services, expressed in mandatory language: "A State plan for medical assistance must . . . provide . . . for payment of the reasonable cost (as determined in accordance with standards approved by the Secretary and included in the plan) of inpatient hospital services provided under the plan." This original payment provision set a basic pattern that has been followed in all subsequent revisions: a fundamental federal standard for

payment to hospitals obligatory upon participating states;¹ state authority to devise the particular method of carrying out the federal payment standard;² and some form of administrative oversight by the federal Secretary.

This congressional mandate that state Medicaid plans provide for payment to hospitals of reasonable costs was enforced both by the Secretary's review process and through hospital suits brought in federal court for equitable relief. In *Catholic Medical Center v. Rockefeller*, 305 F. Supp. 1268 (E.D.N.Y. 1969) (3-judge court), *aff'd*, 430 F.2d 1297 (2d Cir.), *appeal dismissed*, 400 U.S. 931 (1970), a group of hospitals brought an action against state officials predicated on § 1983, *see* 305 F. Supp. 1256, 1260 (interim opinion), *remanded*, 397 U.S. 820 (1970), and alleging that the state Medicaid plan was in conflict with the Act's reasonable cost payment requirement. The district court rejected the suggestion that federal court adjudication of this issue interfered with the Secretary's oversight, 305 F. Supp. at 1270 ("the court does not interfere with the Secretary's administrative powers, but effectively undergirds them"), held the state plan in violation of the Act, and issued a declaratory judgment which was affirmed on appeal. *Id.* at 1271.

Catholic Medical Center was not an anomaly; during the same period, this Court was affirming the availability of § 1983 actions "to resolve disputes as to whether federal funds allocated to the States are being expended in conso-

¹ "Once a State voluntarily chooses to participate in Medicaid, the State must comply with the requirements of Title XIX and applicable regulations." *Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985).

² The House report accompanying the Act observed that "payment may be made on various bases" while noting the congressional intent that state payment plans "approximate as closely as practicable the actual cost . . . of services rendered." H.R. Rep. No. 213, 89th Cong., 1st Sess. 32 (1965).

nance with the conditions that Congress has attached to their use." *Rosado v. Wyman*, 397 U.S. 397, 422-23 (1970) (recipient suit involving AFDC provisions of the Social Security Act).³ Thus, it was against the background of federal court enforcement of the rights secured by the Social Security Act that Congress turned to revise the Medicaid hospital payment standard.

2. In the early 1970s, Congress concluded that the original payment provision of the Act had not proven entirely satisfactory. The Secretary had equated the Medicaid standard with the Medicare reimbursement formula, which "provoked sharp criticism for doing nothing to hold down the spiraling costs of medical assistance programs." *Massachusetts Hosp. Ass'n v. Harris*, 500 F. Supp. 1270, 1274 (D. Mass. 1980). Congress responded to these problems with the Social Security Amendments of 1972, Pub. L. No. 92-603. Congress concluded that the Secretary's interpretation of the hospital payment standard was too inflexible and that states should possess enough flexibility to "develop their own methods and standards for reimbursement." H.R. Rep. No. 231, 92d Cong., 2d Sess., reprinted in 1972 U.S. Code Cong. & Admin. News 5087. At the same time, the legislative history of the Amendments reflects Congress's continuing intention to require states to "pay the actual and direct cost of providing care." *Id.* See also S. Rep. No. 1230, 92d Cong., 2d Sess. 325 (1972). Section 232 of the Amendments⁴ permitted states "generally, to develop their own methods of reasonable reimbursement of hospitals rather than being required to follow the medicare regulations," H.R. Conf. Rep. No.

³ Two years later, summarizing *Rosado*'s holding, the Court stated "suits in federal court under § 1983 are proper to secure compliance with the provisions of the Social Security Act on the part of participating States." *Edelman v. Jordan*, 415 U.S. 651, 675 (1974).

⁴ Former 42 U.S.C. § 1396a(a)(13)(D) (1976).

1605, 92d Cong., 2d Sess., reprinted in 1972 U.S. Code Cong. & Admin. News 5386, but required the states to obtain the Secretary's approval prior to implementation.

The federal courts correctly interpreted the 1972 revisions of the Medicaid provider payment requirements as intended to preserve for the states "great flexibility in the areas of cost-finding and rate-setting," *Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388, 392 (5th Cir. 1980), without thereby withdrawing from providers the ability to vindicate their right to payment in accordance with the Act's standards.⁵ The ability of providers to sue under various titles of the Social Security Act had "by now been well-established," *National Union of Hospital & Health Care Employees v. Carey*, 557 F.2d 278, 280 (2d Cir. 1976) (discussing standing).

3. In the mid-1970s several states imposed freezes on their Medicaid payment rates.⁶ At least one state did so without first obtaining the Secretary's approval and persisted even after the Secretary cited it for non-compliance with the Act.⁷ Fears were expressed that the existing administrative means for dealing with such state action

⁵ See, e.g., *Massachusetts Gen. Hosp. v. Sargent*, 397 F. Supp. 1056 (D. Mass. 1975) (reasonable cost requirement enforceable through declaratory judgment); *Wisconsin Hosp. Ass'n v. Schmidt*, [1976-77 Transfer Binder] CCH Medicare & Medicaid Guide ¶27,818 (E.D. Wis. 1976) (injunction entered against state plan's violation of providers' rights under the payment provision).

⁶ See H.R. Rep. No. 1122, 94th Cong., 2d Sess. 6-7 (1976) (letter from Department of HEW).

⁷ See *State Compliance with Federal Medicaid Requirements: Hearings Before the Subcomm. on Health of the Senate Committee on Finance*, 94th Cong., 2d Sess. 3-5, 7-8 (1976) (statement of Stephen Kurzman, Assistant Secretary for Legislation, Department of HEW) (henceforth, "Statement of Assistant Secretary Kurzman").

were both too slow and too clumsy,⁸ while the federal courts were incapable of providing "retroactive relief to providers who may have been injured" by state violations of the Act.⁹ Congress responded, at the very end of its 1975 session and without full committee consideration, by enacting Pub. L. No. 94-182 (former 42 U.S.C. §§ 1396a(a)(13)(g) and 1396b(1) (Supp. V 1975)), which required that a state plan include a provision waiving the state's eleventh amendment immunity from actions for damages "with respect to the application of [the hospital payment provision] to services furnished" under Medicaid. The statute required the Secretary to impose a penalty of 10 percent of the federal Medicaid matching funds otherwise available to any state that failed in any quarter to include such a waiver, thus subjecting states to this penalty if, for whatever reason, they had not executed a waiver by March 31, 1976.

The waiver requirement generated vigorous opposition from the states, H.R. Rep. No. 1122, *supra*, at 4,¹⁰ and it was repealed the following October. See Pub. L. No. 94-552. The legislative history of the 1976 repealer clearly

⁸ 121 Cong. Rec. 42,259 (Dec. 19, 1975) (remarks of Sen. Taft) (the existing administrative remedy, which required total withholding of federal funds in areas of payment in which the state was not in compliance, "is such a severe move that it is inconceivable"); Statement of Assistant Secretary Kurzman, *supra*, at 4.

⁹ Statement of Assistant Secretary Kurzman, *supra*, at 3 (citing states' eleventh amendment immunity from actions for damages).

¹⁰ The legislative history of the statute repealing the waiver requirement indicates that some states objected to the constitutionality of Pub. L. No. 94-182, that many legislatures had found it literally impossible to comply by the date necessary to avoid the 10 percent penalty, and that virtually all the states were concerned, as was the Secretary, that the waiver would lead to litigation on matters unconnected with the particular problem of state plan non-compliance. H.R. Rep. No. 1122, *supra*, at 4-5; 122 Cong. Rec. 13,492 (May 12, 1976) (remarks of Rep. Rogers).

states Congress's intent that providers possess "legal rights" to payment in accordance with the Act. S. Rep. No. 1240, 94th Cong., 2d Sess., reprinted in 1976 U.S. Code Cong. & Admin. News 5650, rights that the repealer was in no way intended to affect. Both Congress and the Secretary unmistakably recognized that the providers' ability to protect their rights through federal court actions for equitable relief was neither created by the 1975 waiver requirement nor altered by the 1976 repealer.¹¹ The Senate report, after proposing that the Secretary adopt regulations to address the problem of state underpayment to providers, stated unequivocally that neither the development of such regulations nor the repealer itself should be "construed as in any way contravening or constraining the rights of the providers of Medicaid services" to seek equitable relief "in a federal or state judicial forum," *id.* at 4, 1976 U.S. Code Cong. & Admin. News 5651.¹² The defendants' assertion, Brief of Petitioners 21 ("Pet. Br."), that by eliminating damages actions against states Congress "expressly rejected federal litigation over this subject" is plainly wrong.

¹¹ See H.R. Rep. No. 1122, *supra*, at 4 ("providers could sue to enjoin action," in context clearly referring to federal court suits); *id.* at 7 (letter from Department of HEW) (after repeal of waiver requirement, "providers can continue, of course, to institute suit for injunctive relief in State or Federal courts, as necessary"); 122 Cong. Rec. 13,492 (May 12, 1976) (remarks of Rep. Rogers) ("the provider can sue the State to enjoin action"); Statement of Assistant Secretary Kurzman, *supra*, at 3 ("Access to Federal courts is available for injunctive relief against State officials."). The courts interpreted the repealer's effect in accordance with the congressional and executive understanding. See, e.g., *Hospital Ass'n v. Toia*, 435 F. Supp. 819, 831 (S.D.N.Y. 1977) (the repealer affected neither providers' "substantive right" nor their ability "to sue in federal court" for equitable relief).

¹² The regulations proposed by the Senate report, which the report expressly stated would not preclude judicial review, were far more extensive than those actually mandated by Congress in 1977, see 42 U.S.C. § 1396a(a)(37)(1982), or ever adopted by the Secretary.

4. In 1980 and 1981 Congress revised the Medicaid Act's requirements for state payments to providers,¹³ adopting in successive sessions the basic requirement for nursing home and hospital payments now found in § 1396a(a)(13)(A). As in 1972, Congress intended to afford states "greater latitude in developing and implementing alternative reimbursement methodologies that promote the efficient and economical delivery of such services." H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981). Congress attributed much of the blame for the problems with the existing standards to the inefficiency, complexity and rigidity of the Secretary's administration of the Act,¹⁴ and therefore acted to reduce sharply the Secretary's role in the administration of Med-

¹³ In 1980 Congress enacted the "Boren Amendment," Pub. L. No. 96-499, § 962(b), which established the current standard for payments to nursing homes. The following year, Congress extended the Boren Amendment, with certain additional requirements, to hospital payments, Pub. L. No. 97-35, § 2172. The combined 1980 and 1981 revisions are codified at the present 42 U.S.C. § 1396a(a)(13)(A). The VHA agrees with the defendants, Pet. Br. 19-20 & n.12, that the legislative history of both the 1980 and 1981 acts, as well as the nursing home portions of the 1979 Senate Report that first addressed the revisions, are relevant in determining the intent of Congress in enacting § 1396a(a)(13)(A).

¹⁴ See S. Rep. No. 471, 96th Cong., 1st Sess. 28, 29 (1979) ("complex and long-delayed Federal regulations have unduly restrained [the states'] administrative and fiscal discretion" and imposed "marginal but massive paperwork requirements" on both states and providers); *Medicaid and Medicare Amendments: Hearings on H.R. 4000 (and All Similar Bills) Before the Subcomm. on Health and the Environment of the House Comm. on Interstate and Foreign Commerce*, 96th Cong., 1st Sess. 846 (1979) (statement of Senator David L. Boren) (henceforth "Statement of Sen. Boren"); (criticizing HEW's "unfortunate[]" adoption of "detailed and complex regulations"); H.R. Rep. No. 158, *supra*, at 292 (HHS administration of state proposals to use non-Medicare payment methods, an option intended to be available under the 1972 provision, "generally" compelled states to follow the Medicare basis).

icaid provider payments and to effect "the removal of the burdensome costs, paperwork and frustration of Federal cost-reimbursement regulations." Statement of Sen. Boren, *supra*, at 848. Congress intended the Secretary to keep "regulatory and other requirements to the minimum necessary to assure proper accounting, and not to overburden the States and facilities" with red tape, S. Rep. No. 139, 97th Cong., 1st Sess. 478, *reprinted in 1981 U.S. Code Cong. & Admin. News 744*.

This reduction of federal administrative oversight was intended to result in "no reduction" in the responsibility of the states to abide by the Act's payment requirements. "On the contrary, the amendment would require accountability on the basis of results of the State's system rather than measurements of presumed compliances with a maze of regulatory and procedural details." Statement of Sen. Boren, *supra*, at 848. Just as before, the Act would forbid state plans from setting payment rates "lower than the applicable *legal requirements* would *mandate*." H.R. Rep. No. 1179, 96th Cong., 2d Sess. 154 (1980) (emphasis added). The legislative history unmistakably demonstrates Congress's unchanged intention to require states to pay providers in accordance with the (now revised) statutory standards.¹⁵

¹⁵ See also S. Rep. No. 471, *supra*, at 28-29 (amendment "gives the States flexibility and discretion, subject to the statutory requirements of this section and the existing requirements of section 1902(a)(30) and section 1121 of the Act") (emphasis added); *id.* at 29 (state flexibility "not intended to encourage arbitrary reductions in payment that would adversely affect the quality of care"); S. Rep. No. 139, *supra*, at 478, 1981 U.S. Code Cong. & Admin. News 744 (same); Statement of Sen. Boren, *supra*, at 845 (amendment "places responsibility squarely on the States to establish adequate payments"); H.R. Rep. No. 158, *supra*, at 294 (state flexibility not intended "to result in arbitrary and unduly low reimbursement levels for hospital services"). During floor

In adopting the 1980 and 1981 revisions of the payment standards, Congress reiterated its belief that adequate provider compensation is a crucial element in the overall Medicaid program.¹⁶ The defendants' assertion that the provider payment standards are merely preferred "goals" rather than a congressional mandate is flatly contradicted by the clear evidence of the legislative history of the 1980 and 1981 revisions. As the 1981 conference report stated, Congress "intend[s] that State hospital reimbursement policies should *meet the costs* that must be incurred by efficiently-administered hospitals in providing covered care and services to medicaid eligibles as well as the costs required to provide care in conformity with State and Federal requirements." H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess. 962, reprinted in 1981 U.S. Code Cong. & Admin. News 1324 (emphasis added).¹⁷

debate, Senator Boren was asked whether the revised standard would permit states to "set reimbursement levels so low" that they might not be "capable of meeting the costs of quality care." In response, the Senator explained: "[m]y amendment . . . achieves the present law's objective of assuring high-quality care" and "differs from the present law with respect to the methods States may employ in determining reasonable and adequate rates." 126 Cong. Rec. 17,885 (June 30, 1980) (colloquy between Sen. Pryor and Sen. Boren).

¹⁶ "In permitting States greater flexibility in reimbursement system design, the Committee intends the States to ensure that such alternative systems provide fair and adequate compensation for services to Medicaid beneficiaries." H.R. Rep. No. 158, *supra*, at 293. Despite its goal of holding down Medicaid costs, Congress was careful to avoid suggesting that financial containment was a justification for inadequate payment rates. *See, e.g.*, H.R. Rep. No. 1479, 96th Cong., 2d Sess. 154, reprinted in 1980 U.S. Code Cong. & Admin. News 5903 ("The conferees would further note their intent that a State not develop rates under this section solely on the basis of budgetary appropriations.").

¹⁷ The Secretary's interpretation of the current provider payment standards is in accord with the legislative history of the 1980 and 1981 revisions. In issuing the final regulations implementing the revisions,

5. The Court's "evaluation of congressional action . . . must take into account its contemporary legal context." *Cannon v. University of Chicago*, 441 U.S. 677, 698-99 (1979). With regard to the revisions in 1980 and 1981 of the provider payment standards, that context was shaped by an extensive history of congressional, administrative and judicial recognition that Medicaid providers possess a federally secured right enforceable by suits for prospective relief under § 1983.¹⁸

for example, the Secretary referred to "the explicit statutory responsibility of the State agency to make its finding that the methods and standards *result in* reasonable and adequate payment rates," 48 Fed. Reg. 56,046, 56,050 (Dec. 19, 1983) (emphasis added). The puzzling suggestion of the United States as Amicus Curiae that the Act "does not require that rates be reasonable and adequate," U.S. Amicus Br. 10, thus contradicts not only the plain import of the statutory language but also repeated assertions of congressional intent in the provision's legislative history.

¹⁸ See *Samuels v. District of Columbia*, 770 F.2d 187, 194 n.7 (D.C. Cir. 1985) ("Absent affirmative indications to the contrary, then, we cannot assume that Congress implicitly intended to extinguish the plaintiffs' existing ability to enforce [their rights] under section 1983.").

Provider reimbursement suits against state defendants in the period immediately before the 1981 revision include *Massachusetts Gen. Hosp. v. Weiner*, 569 F.2d 1156 (1st Cir. 1978) (defendants prevailed on the merits); *Hospital Ass'n v. Toia*, 577 F.2d 790 (2d Cir. 1978) (claim for prospective relief moot); *California Hosp. Ass'n v. Obledo*, 602 F.2d 1357 (9th Cir. 1979) (judgment for plaintiffs vacated to allow Secretary to fulfill statutory duties); *Florida Nursing Home Ass'n v. Page*, 616 F.2d 1355 (5th Cir. 1980) (injunctive relief and availability of money damages upheld), *rev'd in pt.*, 450 U.S. 147 (1981) (eleventh amendment bars money damages); *Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388 (5th Cir. 1980) (remanded to allow Secretary to fulfill statutory duties); *Alabama Nursing Home Ass'n v. Califano*, 433 F. Supp. 1325 (M.D. Ala. 1977) (plaintiffs prevailed on the merits); *Massachusetts Hosp. Ass'n v. Harris*, 500 F. Supp. 1270 (D. Mass. 1980) (complaint dismissed in part on eleventh amendment and mootness grounds); *Friendship Villa-Clinton, Inc. v. Buck*, 512 F. Supp. 720 (D. Md. 1981) (complaint dismissed on eleventh amendment and mootness grounds).

II.

THE VIRGINIA HOSPITAL ASSOCIATION HAS PROPERLY ASSERTED THE VIOLATION BY THE STATE OF A FEDERAL RIGHT SECURED BY 42 U.S.C. § 1396a(a)(13)(A), A STATUTORY PROVISION BINDING STATES, BENEFITING PROVIDERS, AND WITHIN THE COMPETENCE OF THE COURTS TO ENFORCE UNDER 42 U.S.C. § 1983

In *Golden State Transit Corp. v. City of Los Angeles*, No. 88-840 (U.S. Dec. 5, 1989), this Court summarized the criteria for determining whether a federal right has been violated:

In deciding whether a federal right has been violated, we have considered whether the provision in question creates obligations binding on the governmental unit or rather "does no more than express a congressional preference for certain kinds of treatment." *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 19 (1981). The interest the plaintiff asserts must not be "too vague and amorphous" to be "beyond the competence of the judiciary to enforce." *Wright v. Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 431-432 (1987). We have also asked whether the provision in question was "inten[ded] to benefit" the putative plaintiff. *Id.*, at 430; see also *id.*, at 433 (O'Connor, J., dissenting) (citing *Cort v. Ash*, 422 U.S. 66, 78 (1975)).

Id. at 3. Under these criteria, it is clear that § 1396a(a)(13)(A) of the Medicaid Act secures a federal right on behalf of providers to be paid at rates which are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities.

A. The Provider Reimbursement Provision Of The Act Is Not A Mere "Expression Of Congressional Preference" But Is Instead A Legal Obligation Binding On State Officials

As this Court made clear in *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981), not every violation of federal law is actionable under § 1983. When the provision in question secures a federal right to the plaintiff, however, a § 1983 cause of action does exist. In *Pennhurst*, this Court, recognizing "the well-settled distinction between congressional 'encouragement' of state programs and the imposition of binding obligations on the States," *id.* at 27, found that no substantive rights had been created by the statutory provision in question, § 6010 of the Developmentally Disabled Assistance and Bill of Rights Act. *Id.* at 11. The Court noted that the statutory provision relied upon by the *Pennhurst* plaintiffs was merely the preamble of the Title, setting forth the rationale for the conditions imposed by the remaining sections; *id.* at 24 n.18; that it was written "merely in precatory terms;" that it did "no more than express a congressional preference for certain kinds of treatment," *id.* at 19; that no authority was conferred upon the federal Secretary to withhold funds for state non-compliance with the provision, *id.* at 23; that the amount appropriated by Congress (\$1.6 million) was so "woefully inadequate to meet the enormous financial burden" potentially imposed by the provision that "Congress must have had a limited purpose in enacting" it, *id.* at 24; and that given the "massive obligation" of providing treatment in "the least restrictive setting," *id.*, it is "unlikely that a State would have accepted [the small amount of] federal funds had it known that it would be bound to provide such treatment." *Id.* at 27.

In every material respect, the instant case is sharply different, and the principles of *Pennhurst* require recogni-

tion that a substantive federal right has been secured by the statutory provision in question. First and foremost, the language of the statutory provision is mandatory, not precatory. Unlike the statute reviewed in *Pennhurst*, the Medicaid Act does confer authority upon the federal Secretary to withhold funds for state non-compliance with the conditions of § 1396a. 42 U.S.C. § 1396c (1982). For states that elect to participate in the program, reimbursement of Medicaid providers is not an option "encouraged" by Congress, but a requirement flatly mandated by § 1396a(a)(13)(A): "A state plan for medical assistance *must* provide for payment . . . of the hospital . . . services . . ." (emphasis added).

It cannot be that this mandatory provision leaves states free to pay any amount they choose. The statutory requirement that participating states reimburse providers would obviously be meaningless if a state could, without limit, simply adopt any reimbursement method it chose, and pay as little as it wished. The statute requires that payment be made through the use of rates that the state finds

are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services [that meet legal standards of quality and safety] and assure that [eligible] individuals have access . . . to inpatient hospital services . . .

As the court of appeals concluded in *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11 (3d Cir. 1989): "[t]he language of this subsection is 'cast in the imperative . . . and succinctly sets forth a congressional command, which is wholly uncharacteristic of a mere suggestion or 'nudge' . . . in the direction of providing appropriate reimbursement of hospitals treating medicaid patients." *Id.* at 20.

The defendants and the Solicitor General suggest that the mandate that a state reimbursement plan satisfy these requirements does not actually impose any limitation whatsoever on a state's discretion to pay whatever it chooses. The only statutory requirement, as they would have this Court read the statute, is that the state make "assurances" to the Secretary. Whether those "assurances" are true or false is, in their view, irrelevant.

Statements that the statutory provision "does not require that rates be reasonable and adequate," U.S. Amicus Br. 10, and only requires "the submission of assurances" to the Secretary, Pet. Br. 15, ignore the fact that the statute expressly requires, before any assurances are made to the Secretary, that a state *find* that its plan will produce reasonable and adequate rates.¹⁹ These requirements—(1) that the state find that its plan will meet the congressionally-mandated provider reimbursement standard; and (2) that the state make "assurances satisfactory to the Secretary" that it has done so—are separate and distinct. As Judge Posner noted in an analogous context: "The second requirement is a backstop for the first." *Edgewater Nursing Center v. Miller*, 678 F.2d. 716, 718 (7th Cir. 1982) (provider suit under 1972 nursing home payment standards). The defendants cannot satisfy the first requirement by arguing that they have met the second.²⁰ As

¹⁹ The Secretary's regulations require each state to make annual findings that its reimbursement plan continues to meet federal statutory standards. Assurances to the Secretary, however, need not be made annually, but only when changes in payment methods and standards are made. 42 C.F.R. § 447.253(a) and (b) (1988).

²⁰ The defendants' assertion that the statute does not require that a state plan in fact provide for reasonable and adequate reimbursement, but requires only that "assurances satisfactory to the Secretary" be submitted to the Secretary, would ironically leave the Secretary with no basis whatsoever for finding any assurances unsatisfactory.

the history of congressional consideration of the provider reimbursement standard makes clear, see Part I, *supra*, Congress intended that states actually comply with the statutory standard, and not merely make self-serving findings of compliance.²¹ The court of appeals below correctly concluded that “§ 1396a(a)(13)(A) reveals a congressional intent to condition federal assistance on states’ achievement of the express purposes of the section and not simply on states’ assurances of compliance” (footnote omitted). *Virginia Hosp. Ass’n v. Baliles*, 868 F.2d 653, 658 (4th Cir.), cert. granted, 110 S. Ct. 49 (1989).

Both states and Medicaid providers were clearly on notice that reasonable and adequate reimbursement to providers was mandatory for those states that chose to participate in the Medicaid program.²² A state could not

²¹ Other sections of the Medicaid Act refer to the provider reimbursement standard as a mandatory obligation, not as a mere goal or preference. See for example, 42 U.S.C. §§ 1396r-4(a) and (e) (1989 supp.) (referring to “the requirement” of § 1396a(a)(13)(A) regarding “payments to hospitals”).

²² In *Pennhurst*, this Court noted that Congress appropriated the “woefully inadequate” amount of \$1.6 million for the state’s program and could not reasonably have expected states to voluntarily undertake the “massive obligation” of totally restructuring their entire institutionalized persons system as a condition of receiving such small grants. 451 U.S. at 24. Here, in contrast, Congress has appropriated over \$29 billion dollars for the Medicaid program, and pays from 50 to 83% of the total patient cost. U.S. Amicus Br. 2. It would thus be reasonable for both Congress and the states to assume that a state’s decision to participate in the program carried substantial obligations.

Before 1981 states had been paying reasonable costs to all hospitals, not just those whose costs were efficiently and economically incurred. Rather than effecting the major expansion of services at issue in *Pennhurst*, the revision to the payment standard was intended to reduce costs under the Medicaid program. Section 1396a(a)(13)(A) does not require the states to take on massive new obligations, but

meet the “requirements” imposed by the Secretary’s 1983 regulations without demonstrating that, under its plan, its “agency pays for inpatient hospital services . . . through the use of rates that are reasonable to meet the costs that must be incurred by efficiently and economically operated providers.” 42 C.F.R. 447.253(a) & (b)(1)(i) (1988). Empty assurances do not satisfy this regulation. The Secretary’s interpretation of the Act was that “the explicit statutory responsibility of the State agency” was to find that its plan would “result in reasonable and adequate payment rates.” 48 Fed. Reg. at 56,050 (Dec. 19, 1983).²³

There is no indication anywhere in the public record that any state was so cynical as to assume that it could—simply by making “findings” that were not in fact true—accept federal Medicaid funds while flagrantly failing to conform to the provider reimbursement standard. It was clear to everyone involved that the obligation imposed by Congress was not to be rendered wholly illusory by a state’s arbitrary and capricious finding that its plan meets the federal statutory standard when it fails to do so in fact.

simply to pay reasonably and adequately for those services it has chosen to provide.

²³ Virginia asserts in its own plan that in accordance with these regulations, it “establishes payment rates that *are* reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities.” Virginia State Plan, Attachment 4.19A at 4 (Sept. 1, 1988) (emphasis added), see appendix to this brief. Virginia is thus hardly in a position to claim that it was “unaware of the conditions [of receiving federal funds] or is unable to ascertain what is expected of it,” *Pennhurst*, 451 U.S. at 17. The state plan, moreover, expressly asserts, not simply that “assurances” have been made to the Secretary, but that it in fact complies with the “reasonable and adequate” reimbursement requirement.

B. The Statutory Provision In Question Was Intended To Benefit Providers

In *Golden State*, this Court noted that in determining whether a statutory provision created a federal right, “[w]e have also asked whether the provision in question was ‘inten[ded] to benefit’ the putative plaintiff.” Slip op. at 3.

The “provision in question” in this case was clearly “inten[ded] to benefit” providers. Hospitals providing treatment to Medicaid patients are directly and immediately benefited by the provision. The “statutory language” at issue is unquestionably “phrased in terms of the persons benefited”: “A state plan for medical assistance must provide for payment . . . of the hospital” 42 U.S.C. § 1396a(a)(13)(A)(emphasis added). As the Court of Appeals for the Third Circuit noted, “[t]he section sets up a plan for the adequate and reasonable reimbursement of hospitals which serve medicaid patients, and thus the hospitals are the section’s ‘beneficiaries.’” *West Virginia Univ. Hosps.*, 885 F.2d at 20.

The defendants confuse the issue by suggesting that it is not sufficient that the statutory provision in question was “inten[ded] to benefit” providers.²⁴ The defendants and

²⁴ The defendants’ confusion on this point arises from their belief that the decisions of this Court have now wholly merged two previously distinct lines of cases: those based on § 1983 and those in which this Court has, on its own authority and by implication, created a remedy where none has been provided by Congress. While there may be points of overlap in the analysis of the two lines of cases, the issue before this Court under § 1983 is in important respects fundamentally different from the issues raised when this Court is asked to create an “implied” remedial cause of action. As the Court of Appeals for the Fifth Circuit recently stated:

To establish an implied private right of action under a federal statute, a plaintiff bears the relatively heavy burden of demonstrating that Congress affirmatively contemplated private enforcement when it

some of their amici suggest that this Court must look not to the statutory provision applicable to this case but rather to some larger statute (although they do not agree on which larger statute). They argue that Medicaid providers are not the intended beneficiaries of “the Medicaid program,” Pet. Br. 15-16, or of “the Social Security Act,” Brief for Connecticut *et al.* as Amici Curiae 2-3. But as this Court has stated

passed the relevant statute. See, e.g., *Merrill Lynch, Pierce, Fenner & Smith v. Curran*, 456 U.S. 353, 377-78 (1982); *Cannon v. University of Chicago*, 441 U.S. 677, 688 (1979).

Plaintiffs do not bear the same burden in seeking to establish a section 1983 right of action. The issue is not the intent of Congress to permit a section 1983 action, but rather the intent of Congress to withdraw the existing section 1983 remedy. The burden of establishing such intent rests on the defendant.

Victorian v. Miller, 813 F.2d 718, 721 (5th Cir. 1987) (citing *Wright*, 479 U.S. at 424).

The difference between the judicial standards applied in the two lines of cases arises from the critical fact that under § 1983 Congress itself has determined that in a limited category of cases—those in which a government official, acting under color of state law, has deprived a person of rights secured by the laws of the United States (and, if a state officer is sued in his or her official capacity, only insofar as prospective relief is sought)—federal courts should be available to provide a remedy. As Professor Sunstein has written, “[r]ecognition of a right of action under section 1983 avoids most of the problems associated with implied causes of action. Most fundamentally, the critical problem—that of judicial authority—disappears. . . . [B]y hypothesis, section 1983 authorizes the statute to be privately enforced. *Thiboutot* is in no sense inconsistent with the Court’s curtailment of implied causes of action, but instead confirms the elementary proposition that the courts must recognize and enforce rights of action that Congress has created.” Sunstein, *Section 1983 and the Private Enforcement of Federal Law*, 49 U. Chi. L. Rev. 394, 415-16 (1982).

If the same standards were to be applied in § 1983 actions as in “implied rights” cases, § 1983 would have no utility since a remedial action would be available under § 1983 only in those cases in which the Court would have implied a remedial action on its own authority. The defendants’ suggestion that these two lines of cases be “merged” is thus, at a minimum, a suggestion that this Court’s decision in *Maine v. Thiboutot* be overruled.

this Term, the relevant issue is whether the “*provision in question* was ‘inten[ded] to benefit’ the putative plaintiff.” *Golden State*, slip op. at 3 (emphasis added). *See also Wright*, 479 U.S. at 433 (O’Connor, J., dissenting): “We have looked first to the *statutory language*, to determine whether it is ‘phrased in terms of the person benefited.’”

The Court of Appeals for the Third Circuit recently provided the correct response to the defendants’ argument:

We recognize, of course, that the primary purpose of medicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it. It does not necessarily follow, however, that Title XIX grants substantive rights *only* to medicaid patients. Although the broad purpose of the Medicaid Act as a whole is to help the poor attain medical care, *the specific purpose of section 1396a(a)(13)(A) is to assure state compliance with some federal standard of hospital reimbursement.*

West Virginia Univ. Hosps., 885 F.2d at 20 (emphasis added). Here it is clear that a statutory provision specifying that a state plan “must provide for payment . . . of the hospital” was intended to benefit hospitals by ensuring adequate reimbursement for their services.

C. The Statutory Language And Decisions By The Federal Courts Enforcing The Provider Reimbursement Standard Clearly Demonstrate That The Provision Is Not “Too Vague And Amorphous” To Be “Beyond The Competence Of The Judiciary To Enforce”

The provision at issue in this case—the requirement that Medicaid providers be reimbursed, and that state plans provide for reimbursement rates that are “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities”—is not so

vague and amorphous that it cannot be considered legally binding. In *Wright v. Roanoke Redevelopment and Housing Authority*, 479 U.S. 418 (1987), this Court held that a regulation requiring a “reasonable” utilities allowance for public housing tenants was sufficiently capable of enforcement to be a federal right. *Id.* at 431. *Wright* established that a provision that contains the word “reasonable” is enforceable by the courts. While some statutes that contain “reasonableness” standards may not be within the capacity of the courts to enforce,²⁵ § 1396a(a)(13)(A) is not one of them.

Much depends upon the context of the phrase in the statutory provision. Like the “reasonable utilities allowance” in *Wright*, a standard requiring a reasonable and adequate rate for cost reimbursement contains ascertainable standards. It is possible, for example, to conclude with confidence that *some* methods of computing reimbursement rates are manifestly unreasonable.

In the instant case, the language of “reasonable and adequate” does not stand alone; it modifies “rates” and is addressed to the fit that Congress requires between the state-determined rates and the “costs” of an efficiently operated provider. While this type of required fit is one that does not pin down the rate-setter to a specific figure, it does require

²⁵ For an example of a statutory provision that may be so vague and open-ended that Congress may well have concluded that “the [appropriate federal] agency, and not the court, has the primary responsibility to determine the statute’s proper reach,” see Sunstein, *supra*, 49 U. Chi. L. Rev. at 428 n.128, citing, among other examples, 7 U.S.C. § 136d(b) (conduct that “generally causes unreasonable adverse effects on the environment” is unlawful).

A requirement of reasonable and adequate reimbursement of costs is significantly more concrete than the example listed above. And, as shown in Part III, *infra*, Congress chose to reduce, not enhance, the federal administrative review of state plans, leaving the federal courts as the only body to provide effective enforcement of the requirements of the statutory provision.

that the rate-setting process be designed to produce rates that will fall within a "zone of reasonableness." *Wisconsin Hosp. Ass'n v. Reivitz*, 733 F.2d. 1226, 1233 (7th Cir. 1984).

The actual experience of federal courts in applying the reimbursement standard in litigation establishes that the standard is "not 'too vague and amorphous' to be 'beyond the competence of the judiciary to enforce,'" *Golden State*, slip op. at 3 (quoting *Wright*, 479 U.S. at 431-32). The decisions that have been handed down under § 1396a(a)(13)(A) demonstrate that the courts can identify clear instances of unreasonable and inadequate state plans. The Court of Appeals for the Tenth Circuit, for example, sustained a challenge by hospital providers in *AMISUB (PSL), Inc. v. Colorado Department of Social Services*, 879 F.2d 789 (10th Cir. 1989). In *AMISUB*, the state officials had developed a methodology for determining the reasonable cost of providing treatment to Medicaid patients and then simply reduced the amount to be paid by approximately one-half. The state officials' evidence at trial was "flagrantly devoid of any effort to make the federally required findings." *Id.* at 796. The "budget adjustment factor" that resulted in "a 46% decrease in provider reimbursement rates," the court found, "has no relation to the actual costs of hospital services." *Id.* at 792. As a result, "no Colorado hospital, no matter how efficiently and economically operated, will be reasonably and adequately compensated to meet the costs that must be incurred." *Id.* at 797.²⁶

²⁶ The courts of appeals have demonstrated that meaningful criteria are available for distinguishing those instances in which providers have sustained their burden of showing that a state plan failed to meet the federal standard from those in which they have not. The same court that decided *AMISUB* rejected a nursing home provider challenge under § 1396a(a)(13)(A), *Colorado Health Care Ass'n v. Colorado Dep't of Social Servs.*, 842 F.2d 1158 (10th Cir. 1988) (removal of certain incentive allowances for nursing homes does not violate federal requirement of reasonable and adequate payment).

West Virginia University Hospitals, Inc. v. Casey provides another example of egregious state non-compliance with the federal provider reimbursement standard. In that case, the provider alleged that the state plan for reimbursement of out-of-state hospitals serving in-state Medicaid patients fell far short of the floor established by Congress. Among other flaws, the plan failed, in violation of an express requirement of § 1396a(a)(13)(A), to take account of the added costs of an out-of-state hospital with a disproportionate share of Medicaid patients. 885 F.2d at 28. The court of appeals could find no "rational basis for [the out-of-state providers'] grossly diminished reimbursement rates," *id.* at 29, and concluded that it was "simply irrational and arbitrary" and "patently unfair" to utilize the plan's method "when the result is a system that varies so wildly in its reimbursement rates." *Id.* Where a state's policy results in unreasonable and inadequate reimbursement to hospitals, it is not beyond the competence of the court to conclude that the requirements of § 1396a(a)(13)(A) have not been met.²⁷

The statutory provision at issue in this case thus meets all of the indicia of an enforceable federal right: its language is mandatory, the plaintiffs are among its intended beneficiaries, and its terms have proven amenable to competent

²⁷ The courts of appeals that have decided the issue whether providers have a secured right under § 1396a(a)(13)(A) have uniformly concluded that they do. See *West Virginia Univ. Hosps. v. Casey*, 885 F.2d 11 (3d Cir. 1989); *AMISUB (PSL), Inc. v. Colorado Dep't of Social Servs.*, 879 F.2d 789 (10th Cir. 1989); *Virginia Hospital Ass'n v. Baliles*, 868 F.2d 1308 (4th Cir.) cert. granted, 110 S. Ct. 49 (1989); *Coos Bay Care Center v. Oregon Dep't of Human Servs.*, 803 F.2d 1060 (9th Cir. 1986), vacated as moot, 484 U.S. 806 (1987); *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291 (8th Cir. 1985), cert. denied, 479 U.S. 1063 (1987); *Wisconsin Hosp. Ass'n v. Reivitz*, 733 F.2d 1226 (7th Cir. 1984). See also *Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511 (5th Cir. 1983).

judicial enforcement. This case differs from those in which courts must rely entirely upon these factors as a guide to whether Congress did or did not contemplate that its statutory provision would constitute an enforceable right. Here, there is simply no need to speculate. As shown in Part I, *supra*, Congress was clearly aware of, and expressly approved of, provider suits for declaratory and injunctive relief from state violations of the provider reimbursement provision.

The Solicitor General implicitly acknowledges that providers possessed a federal cause of action in 1976. See U.S. Amicus Br. 23 n.16. The 1975 Act of Congress requiring states to waive their eleventh amendment immunity (an act that permitted providers to obtain compensatory damages) would have made absolutely no sense if there were no underlying federal right. And the 1976 repeal of the eleventh amendment waiver provision would similarly have been utterly unnecessary if there were no underlying federal cause of action upon which to base suits for damages. Both the adoption and the repeal of the waiver of eleventh amendment immunity are predicated on the congressional understanding that the provider reimbursement provision creates a right enforceable in federal court. Nothing could be clearer than the numerous, consistent congressional statements that "providers can continue . . . to institute suit in State or Federal courts, as necessary." H.R. Rep. No. 1122, *supra*, at 7.

The Solicitor General's bald assertion, U.S. Amicus Br. 23 n.16, that some (unspecified) changes in the statutory language in the 1981 revision silently took away providers' right to sue cannot survive a comparison of the provider reimbursement provision in its 1972 and 1981 forms.²⁸

²⁸ The 1972 hospital reimbursement provision required that a "State plan for medical assistance must . . . provide for payment . . . of the

Far from having rendered the provider reimbursement provision amorphous, the 1981 amendment created a more detailed list of requirements for state plans. While it also lessened the role of the Secretary, this increases rather than weakens the case for judicial enforcement of the provision.

Since Congress has been expressly aware that providers have for two decades been able to enforce the provider reimbursement standard in federal court, and took specific actions in 1975 and 1976 premised upon that assumption, there is no reason for this Court now to presume that Congress did not intend its mandatory requirements to continue to secure rights enforceable in actions for prospective relief under § 1983. As shown in Part III, *infra*, Congress has chosen not to provide any comprehensive alternative remedial scheme, and to rely on providers' right

reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards . . . which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan" 42 U.S.C. § 1396a(a)(13)(D) (1972).

The 1981 revision of the provision imposed the additional requirement that the state's "methods and standards" of payment "take into account" the additional costs of hospitals serving a "disproportionate number of low income patients with special needs." The fundamental obligation to reimburse providers the costs of affording services to Medicaid patients, expressed in 1972 in terms of "reasonable cost," was rewritten in 1981 to require state plans to "provide for payment . . . through the use of rates . . . which the State finds . . . are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" The revision also eliminated the requirement that the state plan, before its implementation, be "approved by the Secretary." 42 U.S.C. § 1396a(a)(13)(A)(1982).

Both the earlier and current versions of the provider reimbursement provision are set out in full in the appendix to this brief.

to sue in federal court as a check against failure by state officials to abide by the legal requirements that Congress has imposed.

III.

THE DEFENDANTS HAVE NOT DISCHARGED THEIR BURDEN OF SHOWING THAT CON- GRESS HAS WITHDRAWN THE SECTION 1983 REMEDY BY CREATING A COMPREHENSIVE ALTERNATIVE REMEDIAL SCHEME: CON- GRESS CREATED NO SUCH ALTERNATIVE SCHEME AND NONE EXISTS

As was shown in Parts I and II, *supra*, congressional consideration of provider reimbursement remedies during the 1970's establishes that Congress was fully aware of, and approved, provider suits for prospective relief as a remedy for violations of the reimbursement requirement. It is clear that Congress had not, prior to the 1980 and 1981 revisions, intended to create any comprehensive alternative remedial system that would oust providers' right to sue under § 1983. Since these revisions *reduced* the availability of the Secretary's review as a possible provider remedy, they could not conceivably have been intended as a new remedy ending access to state and federal courts under § 1983. Moreover, since the scope of any state relief is determined by each state, the defendants have made no showing whatsoever of any congressionally mandated, comprehensive, alternative remedial system that would establish a congressional intention to revoke the established right of providers to challenge the legality of state plans under § 1983.

A. Providers May Enforce Their Rights By Means Of A Suit Under Section 1983 Unless The Defendants Can Demonstrate That Con- gress Has Expressly Withdrawn The Section 1983 Remedy By Providing An Exclusive, Comprehensive Alternative Remedial Scheme

Even when a plaintiff has asserted a federal right, the defendant may attempt to show that Congress has expressly foreclosed a remedy under § 1983 by providing a comprehensive alternative enforcement mechanism for protecting that federal right. See *Golden State Transit Corp. v. City of Los Angeles*, No. 88-840, slip op. at 3 (U.S. Dec. 5, 1989); *Smith v. Robinson*, 468 U.S. 992, 1003 (1984). But the defendants bear the burden of demonstrating that Congress has withdrawn the § 1983 remedy. *Golden State*, slip op. at 3-4, and they must show that Congress expressly intended this result, *id.*, or in other words, that there is "a clear congressional mandate" to withdraw the § 1983 remedy. See *Middlesex County Sewerage Auth. v. National Sea Clammers Ass'n*, 453 U.S. 1, 31 (1981) (Stevens, J., concurring in the judgment). The Court does "not lightly conclude that Congress intended to preclude reliance on § 1983 as a remedy" for the deprivation of a federally secured right." *Wright v. Roanoke Redevelopment and Hous. Auth.*, 479 U.S. 418, 423-24 (1987) (quoting *Smith*, 468 U.S. at 1012 (1984)).

In attempting to discharge this burden, it is not enough to show the existence of alternative administrative remedies. "The availability of administrative mechanisms to protect plaintiff's interests is not necessarily sufficient to demonstrate that Congress intended to foreclose a § 1983 remedy." *Golden State*, slip op. at 3. See also *Wright*, 479 U.S. at 428; *Patsy v. Board of Regents*, 457 U.S. 496, 516 (1982). Nor is it enough that there exists the possibility of state-court judicial relief: a "state-court remedy is hardly a

reason to bar an action under § 1983, which was adopted to provide a federal remedy for the enforcement of federal rights." *Wright*, 479 U.S. at 429. *See also Monroe v. Pape*, 365 U.S. 167 (1961). The defendants must demonstrate that such alternative remedies were clearly intended by Congress to be the *exclusive* means of redress for aggrieved parties.

In *Wright*, for example, the Court acknowledged that there existed an extensive web of administrative mechanisms, including formal and informal hearings and administrative appeals conducted by impartial decisionmakers, all designed to process individual grievances. 479 U.S. at 426. The Court also acknowledged the federal agency's authority to conduct audits, enforce annual contributions contracts, and cut off federal funds. *Id.* at 428-29. In addition, the Court recognized that tenants could enforce their federal rights in state courts. *Id.* at 429. Yet the Court still concluded that this complex of remedies could not redress class grievances of the kind expressed by the tenants, and that these remedies were insufficient to evidence a congressional intent to withdraw the § 1983 remedy.

In *Sea Clammers*, on the other hand, the provision of an alternative remedial scheme was interpreted to express a congressional intent to withdraw the § 1983 remedy. The Court held that the presence in two federal statutes of "unusually elaborate enforcement provisions, conferring authority to sue . . . both on government officials and private citizens," 453 U.S. at 13, compelled the conclusion "that Congress provided precisely the remedies it considered appropriate." *Id.* at 15. The statutes authorized the federal agency to issue compliance orders and seek civil and criminal penalties; states were required to demonstrate that their officials possessed adequate authority to take enforcement action; interested parties were accorded

standing to seek review of actions of the federal agency in federal courts of appeals; and the statutes even contained citizen-suit provisions authorizing private persons to sue for injunctions. *See id.* at 13-14. It was the presence of private federal judicial remedies in *Sea Clammers* that was thought by the Court in *Wright* to be the crucial evidence of a congressional intent to supplant the § 1983 remedy. *See Wright*, 479 U.S. at 427.

For the defendants to prevail, therefore, they must demonstrate that Congress has created a system of provider remedies so clear and comprehensive that it unmistakably demonstrates an intent to foreclose a remedy under § 1983. This is a heavy burden, and the defendants have failed to discharge it. Not only are such federal and state remedies as do exist under the Medicaid statute, federal regulations and the Virginia state plan, fragmentary and incomplete, but they are highly uncertain as to their scope and effectiveness. Such "remedies" hardly constitute evidence of congressional intent to foreclose the § 1983 remedy.

B. Congress Has Provided Only Limited Federal Administrative Oversight And State Administrative Review

1. The defendants assert that the Secretary "vigorously enforces the Medicaid Act," Pet. Br. 23, and that "[t]his oversight is more direct, more intense and doubtless more effective than the casually-exercised HUD powers found in *Wright*." *Id.* at 24 n. 17. The Secretary, on the other hand, has gone to great pains to deny that he performs so extensive a role as far as § 1396a(a)(13)(A) is concerned. In *Illinois Health Care Association v. Suter*, 719 F. Supp. 1419 (N.D. Ill. 1989), where providers brought suit against the Secretary and state officials, the court granted the Secretary's motion for dismissal, agreeing that his role is "one that does not enmesh him in the details of the State's

compliance with the Act." *Id.* at 1423. Consistent with the Secretary's position, the United States in the present case has carefully avoided relying on the foreclosure argument in attempting to show that no § 1983 remedy exists. On the contrary, the United States acknowledges the limited nature of the supervisory role played by the Secretary. U.S. Amicus Br. 20-21.

The Secretary interprets his role correctly. He is vested with general powers to withhold approval of state plans, 42 U.S.C. § 1316(a) (1982), and to reduce or cease federal payments in respect of plans which no longer conform to the requirements of § 1396a or which are not being faithfully administered, 42 U.S.C. § 1396c. The statutory amendments, however, have changed his role from command-and-control supervision of state compliance with reimbursement requirements to simply determining that the assurances provided by the state are satisfactory. As in *Wright*, 479 U.S. at 428, the statute does not require and the Secretary has not provided any formal procedure for providers to bring to the Secretary's attention alleged violations of the Act or the regulations.

Under the decentralized process established by the 1980 and 1981 revisions, providers cannot expect significant protection from the Secretary.²⁹ The Secretary has interpreted his Department's new role narrowly and has revised

²⁹ It appears to be the practice of the Secretary, absent unusual circumstances, not to look behind the assurances made by the states to determine whether the findings upon which they are based are proper. Recently a federal district court found, on the basis of testimony by an official of HHS, that the Secretary "did not 'look behind' [Pennsylvania's] assurances concerning the adequacy of its reimbursement rates . . . nor did it require Pennsylvania to set forth the Commonwealth's specific findings concerning the adequacy of those rates." *West Virginia University Hospitals, Inc. v. Casey*, 701 F. Supp. 496, 510 (M.D. Pa. 1988), *aff'd in pt., rev'd in pt.*, 885 F.2d 11 (3d Cir. 1989).

state compliance requirements so as to "minimiz[e] the administrative burden." 46 Fed. Reg. 47,964, 47,969 (Sept. 30, 1981). While recognizing that § 1396a(a)(13)(A) stipulates various "basic conditions" with which states must comply, he has not "developed any standard methodology for States to use in ensuring that they meet these standards," believing that "development of this methodology should be the responsibility of each State." 46 Fed. Reg. at 47,970. Nothing in the approach of the Secretary suggests that providers are not entitled to such reimbursement as of right, but it is also clear that the Secretary has no intention of getting involved with disputes between providers and a state about state compliance with the requirements of § 1396a(a)(13)(A). Recourse to the Secretary is not a remedy available to providers by right and does not provide support for preclusion of a provider § 1983 remedy.

2. The Medicaid Act requires states to provide in their plans for the prompt reimbursement of provider claims, 42 U.S.C. § 1396a(a)(37)(A) (1982), and for prepayment and postpayment review procedures, "to ensure the proper and efficient payment of claims and management of the program." § 1396a(a)(37)(B). The Secretary has given effect to this provision through a rule requiring state Medicaid agencies to "provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to *such issues as the agency determines appropriate*, of payment rates." 42 C.F.R. § 447.253(c) (1988) (emphasis added). The states, in other words, determine the scope of administrative redress available to providers.

Virginia has responded by including within the provisions of its plan a three-tiered administrative appeal system. J.A. 32-43. Fundamental issues relating to the plan's

legality, however, are *not* appealable.³⁰ As the United States acknowledges, “[t]he Commonwealth’s Medicaid appeals procedure precludes administrative review of the principles under the state plan.” U.S. Amicus Br. 6. *By its own terms*, therefore, the Virginia appeals procedure precludes the very relief the VHA seeks in the present case.³¹ The only court of appeals to have examined the issue of the required scope of state administrative appeals concluded that all that is necessary under federal law is a state process which provides for verifying the calculation of the payment rates. *See West Virginia Univ. Hosp.,* 885 F. 2d at 31. The state administrative appeal system cannot seriously be regarded as a sufficiently comprehensive remedial substitute for an action under § 1983.

C. The Avenues Of Judicial Redress Available Independent Of Section 1983 Cannot Provide Relief Against State Plans That Fail To Comply With Federal Law

The Medicaid Act contains no specific provision for judicial review at the instance of providers. In addition, the Secretary has taken the view that “[a]bsent any statutory mandate, there is no Federal authority to require judicial recourse (presumably in State courts) for providers dissatisfied with State payment rates.” 48 Fed. Reg. at 56,052. Instead, the Secretary has indicated that providers must rely on “the current State administrative procedures or the

³⁰ Most important for the purpose of this appeal are the calculation of the initial group ceilings on allowable operating costs for inpatient care as of July 1, 1982 and the selection of the prospective escalator index. J.A. 33.

³¹ The defendants seem to attribute significance to the fact that none of the VHA’s members have pursued their appeals. Pet. Br. 7. The obvious explanation, however, is that the state agency has no jurisdiction under the state plan to consider the very issues the VHA’s members wish to dispute.

State and Federal civil court systems.” *Id.*³² If any federal and state court remedies, other than those available under § 1983, were to exist, they would have to be found outside of the framework of the Medicaid Act itself—hardly a basis for the conclusion that Congress intended to withdraw the § 1983 remedy by the express provision of alternative remedies.

While there is nothing in the Medicaid Act that requires state court judicial review, and while the Secretary has specifically declined to impose such a requirement, the defendants attempt to demonstrate that the § 1983 remedy has been foreclosed by the availability, *inter alia*, of state court review under Article 4 of the Virginia Administrative Process Act, Va. Code §§ 9-6.14:15 - 9-6.14:19 (Repl. Vol. 1989). The happenstance of state judicial review—the availability of which is a matter of individual state law—is not a basis from which to deduce clear congressional intent to foreclose the remedy under § 1983. *See Wright*, 479 U.S. at 429. In any event, the availability of state judicial review in Virginia is, contrary to the assumptions of the defendants, Pet. Br. 23, and amici, U.S. Amicus Br. 6, extremely uncertain.

The Virginia Administrative Process Act specifically exempts from its application agency action relating to grants of state or federal funds. Va. Code § 9-6.14:4.1(B)(4).³³ The exemption has not been the subject of interpretation by the Virginia Supreme Court, but has been interpreted in a number of lower Virginia state court decisions and in the decisions of a Virginia federal district court and the federal court of appeals not to cover

³² The Secretary’s position was consistent with his previous representations to Congress. *See Statement of Assistant Secretary Kurzman, supra*, at 3 (“Access to Federal courts is available for injunctive relief against State officials.”).

³³ This exemption was formerly contained in Va. Code § 9-6.14:20, the contents of which were consolidated into the present provision in 1985.

agency action involving public assistance. *See Harris v. Lukhard*, 547 F. Supp. 1015, 1033 (W.D. Va. 1982), *aff'd*, 733 F.2d 1075, 1081-82 (4th Cir. 1984) (citing and relying upon unreported Virginia decisions).³⁴ In the light of these decisions, both the provider-party and the state agreed, in *Mary Washington Hospital v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985), that the Virginia APA was not applicable to agency actions affecting Medicaid. *Id.* at 897. This is still the case.³⁵ Neither the defendants³⁶ nor amici,³⁷ identify

³⁴ After having previously taken a different view, the Attorney General of Virginia, in two 1982 opinions, apparently also took the view, relying on the grant-of-public-funds exemption and in the light of the opinions of the federal district court and Virginia circuit courts, that the Virginia APA did "not apply to the activities of the Virginia Medicaid Program." *See Harris*, 733 F.2d at 1082; Stump & Hanken, *Virginia Should Open its Courthouse Doors to Review Administrative Decisions Involving Public Assistance*, 21 U. Rich. L. Rev. 161, 164 n. 31 (1986).

³⁵ In 1989, the Virginia APA was amended and individual case decisions regarding the grant or denial of Medicaid were rendered subject to the APA's judicial review provisions. Va. Code § 9-6.14:16(B) (Repl. Vol. 1989). But the availability of review was restricted in almost identical a fashion to the way in which the administrative appeals process applicable to providers has been limited. The amendment states: "no appeal pursuant to this article may be brought regarding the adequacy of standards of need and payment levels for public assistance programs . . . *The validity of any statute, regulation, standard or policy, federal or state, upon which the action of the agency was based shall not be subject to review by the court.*" *Id.* (emphasis added). If it is § 9-6.14:16(B) that provides the basis for judicial review of state plans, then the express terms of the Virginia Act itself prevent providers from challenging the underlying validity of those plans, and meaningful state judicial review would be unavailable.

³⁶ The defendants point to § 32.1-325.1 of the Virginia Code, Pet. Br. 23, which became effective on April 3, 1986. Va. Code § 32.1-325.1 (Cum. Supp. 1989). This section, which governs individual determinations by the state agency as to whether overpayments have been made to providers under the state plan, instructs the agency to undertake recovery of overpayments to providers. It also affords providers the

any plausible basis for state judicial review. Even if the availability of state court review were relevant in discerning congressional intent to withdraw the remedies available under § 1983, the defendants have not seriously attempted to discharge their burden of identifying a clear state court remedy, and it appears that none exists.

The Medicaid Act makes no specific provision for federal suits by providers.³⁸ In certain circumstances, courts have

opportunity of administrative appeal against the agency's initial determinations in accordance with Article 3 of the Virginia APA and the state plan, and the same subsection states that "[c]ourt review of final agency determinations concerning provider reimbursement shall be heard in accordance with the Administrative Process Act." § 32.1-325.1(B). By its own terms, this provision is limited in its application to *individual determinations of overpayment* under the state plan; it can hardly be regarded as an appropriate vehicle for seeking state court review of the validity of the plan itself, or apparently, even of *underpayments*.

³⁷ The Solicitor General relies exclusively on the Virginia APA for his assertion that the scope of judicial review is not limited in the same manner as the administrative appeals process. U.S. Amicus Br. 6. The Solicitor General specifically cites to Va. Code 9-6.14:17, which governs the issues that may be the subject of review. Presumably, the Solicitor General has in mind the issue identified as "compliance with statutory authority, jurisdiction limitations, or right as provided in the basic laws as to subject matter." Va. Code § 9-6.14:17(ii) (Repl. Vol. 1989). If so, and even if this provision is broad enough to cover the validity of a state plan itself, it is not clear how providers would manage to bypass the grant-of-public-funds exemption. The amendment enabling recipients of public assistance to seek judicial review expressly precludes this kind of challenge, and the provisions governing determinations of overpayment track the state plan, including its limitations.

³⁸ The Act makes express provision for judicial review of the Secretary's determinations in only one instance: where the Secretary has disapproved a state plan, or amendments to a state plan, submitted to him for approval. In such a case, the state may file a petition for review in the court of appeals for the circuit in which the state is

recognized that Medicaid recipients and providers can obtain review of the Secretary's decisions; in so doing, reliance has been placed on the federal Administrative Procedure Act³⁹ and various federal jurisdictional statutes.⁴⁰ In any event, this form of review is extremely limited as a means of challenging compliance with § 1396a(a)(13)(A).⁴¹ In

located. 42 U.S.C. § 1316(a)(3). In other situations, for example where the Secretary has disallowed federal participation because of a violation of a federal standard in the administration of a plan, *id.* §§ 1396b, 1316(d), the courts have held that the Secretary's decision is reviewable in federal district court under the federal APA and jurisdictional statutes, on the petition of the state concerned. *See, e.g., Bowen v. Massachusetts*, 108 S. Ct. 2722 (1988); *Minnesota v. Heckler*, 718 F.2d 852, 857 (8th Cir. 1983); *Illinois Dep't of Public Aid v. Schweiker*, 707 F.2d 273 (7th Cir. 1983).

³⁹ Federal Administrative Procedure Act review is not available against the states because they do not fall within the definition of "agencies" for the purposes of the APA. *See* 5 U.S.C. § 701(b)(1)(1988). *See, e.g., Mary Washington Hosp. v. Fisher*, 635 F. Supp. 891, 897 (E.D. Va. 1985).

⁴⁰ For example, Medicaid recipients residing in nursing homes were permitted to bring a class action against the Secretary to require the latter to implement a system of enforcement to ensure compliance by provider facilities with the requisite federal standards. *Estate of Smith v. Heckler*, 747 F.2d 583 (10th Cir. 1984). So, too, the right of providers to seek review against the Secretary in respect of his approval of a state plan was recognized by the courts in the pre-Boren Amendment decisions. *See, e.g., Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388 (5th Cir. 1980); *Hospital Ass'n v. Toia*, 438 F. Supp. 866, 868-69 (S.D.N.Y. 1977); *see also Hospital Ass'n v. Toia*, 473 F. Supp. 917, 924, 925-27, 940 (S.D.N.Y. 1979).

⁴¹ In post-Boren Amendment decisions the courts have been reluctant to extend judicial review to the Secretary's approval process, even when they have been prepared to entertain suits against the states. *See, e.g., Nebraska Health Care Ass'n v. Dunning*, 575 F. Supp. 176 (D. Neb. 1983) (citing changed federal/state relationship brought about by Boren Amendment), *aff'd in pt., vacated in pt.*, 778 F.2d 1291 (8th Cir. 1985) *cert. denied*, 479 U.S. 1063 (1987); *Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511, 521-22 (5th Cir. 1983) (refusing to enjoin

view of the limited role played by the Secretary in the formulation of state plans, review of his decisions cannot be regarded as a sufficiently comprehensive remedy, and to the extent that it does not even derive from the Medicaid Act, it can hardly constitute evidence of congressional intent to foreclose remedies under § 1983.

D. The Fragmentary And Uncertain Remedies Available Under The Medicaid Act And Regulations Fall Far Short Of Manifesting An Intent By Congress To Create A Comprehensive Remedial Framework That Forecloses Relief Under Section 1983

The defendants complain that by recognizing that providers have a remedy under § 1983, "the Court of Appeals and the District Court have thwarted and reversed [congressional efforts to reduce federal oversight] by grafting federal judicial review onto the program." "The result," they continue, "is confusing, wasteful of resources and duplicative." Pet. Br. 24. The question the defendants have failed to answer, however, is: "duplicative" of what? Their entire argument begs the question in issue, which is "do providers have a right secured by § 1396a(a)(13)(A)?" None of the "remedies" relied upon provides a satisfac-

implementation of state plan until Secretary defined meaning of "efficiently and economically operated providers" and "hospitals which serve a disproportionate number of low income patients with special needs," and distinguishing *Alabama Nursing Home*, because of changes brought about by Boren Amendment; *Illinois Health Care Ass'n v. Suter*, 719 F. Supp. 1419, 1424 (N.D. Ill. 1989) (to "imply a private right of action against the Secretary would require more than the anticipated limited degree of oversight envisioned for the Secretary"). One court considered the Secretary's role to have been reduced so significantly that it held the Secretary to have properly accepted a state's plan and assurances even though subsequent litigation had shown that those assurances were false. *California Hosp. Ass'n v. Schweiker*, 559 F. Supp. 110, 116 (C.D. Ca. 1982), *aff'd*, 705 F.2d 466 (9th Cir. 1983); *see also Dunning*, 575 F. Supp. at 179.

tory avenue of redress for the vindication of the right of providers to a state plan that guarantees those who are cost-efficient to reasonable and adequate reimbursement for their services. The alternative state and federal remedies identified by the defendants are neither adequate nor even certain, and they come nowhere close to embodying a comprehensive remedial system supplied by Congress in substitution of the remedy under § 1983. The state appeals system is limited to disputes concerning application of the plan; state judicial review is at best confined to the same issues; federal administrative supervision is not designed to scrutinize the details of payment methodology for compliance with the provider reimbursement standard; and federal judicial review based on the Administrative Procedure Act is, for the same reason, speculative and ineffective as a form of redress.

IV

THE SAFEGUARD OF PROSPECTIVE RELIEF UNDER SECTION 1983 IS WHOLLY CONSIS- TENT WITH CONGRESS'S INTENT TO AF- FORD THE STATES REASONABLE FLEXIBIL- ITY IN DEVISING PAYMENT METHODS UNDER SECTION 1396a(a)(13)(A)

The current Medicaid provider payment system, as interpreted by the federal courts of appeals, faithfully embodies Congress's purposes in enacting § 1396a(a)(13)(A). Congress revised the provider payment provisions in 1980 and 1981 to put primary responsibility "squarely on the States to establish adequate payments" to providers. Statement of Sen. Boren, *supra*, at 845. Congress modified the substantive federal standards for determining the adequacy of payment rates in order to make plain the states' ability to devise plans that varied from the Medicare standard, and reduced sharply the Secretary's role. Participating states are responsible for

developing methods and standards for setting provider payment rates and for finding that the resulting rates do in fact satisfy the federal statutory requirements. The Secretary remains responsible for monitoring the processes by which the states make their findings, but does so through a process that affords providers no formal means of participation or redress. Specific complaints by individual providers over particular rates or payment decisions are handled by the administrative appeals process the states are required to establish. Challenges to the legality of the state payment plan as a whole—which a state need not entertain in its appeals process—are to be adjudicated in "the State and Federal civil court systems." 48 Fed. Reg. at 56,052 (comments on final regulations). The result is a coherent system of enforcement.⁴²

The defendants' assertion that the retention of the § 1983 cause of action in cases such as the present one is "confusing, wasteful of resources and duplicative," Pet. Br. 24, is without merit. The

⁴² The defendants characterize § 1983 provider suits against state officials as "federal judicial interference" which, if permitted, would "upset the efficiency and workability of the system devised by Congress" and a "special balance" struck by Congress "between federal and state enforcement in creating and maintaining the unique Medicaid Program." Pet. Br. 28-29. This characterization seeks to marshal in the defendants' support Justice Blackmun's indicium of congressional intent to withdraw the § 1983 remedy in *Smith v. Robinson*, 468 U.S. 992, 1012 (1984) ("Allowing a plaintiff to circumvent the EHA administrative remedies would be inconsistent with Congress' carefully tailored scheme"), quoted in *Golden State*, slip op. at 3. On the contrary, provider suits under § 1983 complement the system created by the Medicaid Act and, with the decentralization of responsibilities brought about by the 1980 and 1981 amendments, are more important than ever if state compliance with federal standards is to be assured. Section 1983 provides a judicial "backstop" to ensure the legality of state plans, thereby complementing the necessarily more generalized, advance oversight performed by the Secretary.

defendants have mischaracterized this case as involving an attempt to secure “*de novo* adjudication of payment disputes in the federal courts.” Pet. Br. 25. In reality, however, the VHA’s action is a systemic challenge to the compatibility of the state’s reimbursement principles with the Act, not a dispute over a particular rate or state administrative decision. The VHA seeks declaratory and injunctive relief against a state payment *plan* that does not satisfy the Act’s requirements, J.A. 21-22, not against individual state reimbursement decisions. By collapsing the distinction between the plan itself and determinations under the plan, the defendants seek to secure immunity from judicial review of their actions. They assert an immunity even more extensive than that enjoyed by the Secretary himself, *under an express statutory preclusion of review*, with respect to Medicare benefit determinations. See 42 U.S.C. §§ 405(h), 1395ii (1982); *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986). In *Bowen*, this Court recognized that §§ 405(h) and 1395ii preclude judicial review of individual Medicare benefit determinations, but rejected the contention that they also prevented review of the *methods* by which such determinations were reached.⁴³ The defendants can identify no express foreclosure of § 1983 review under the Medicaid Act. They attempt to create an implied foreclosure of § 1983 review by pointing to the state administrative process designed to resolve individual claims regarding reimbursement. This argument fails to recognize the fundamental distinction between systemic challenges to method

⁴³ As the Court observed, “[u]nlike the *determinations* of amounts of benefits, the *method* by which such amounts are determined ordinarily affects vast sums of money and thus differs qualitatively from the ‘quite minor matters’ review of which Congress confined to hearings by [the Secretary’s delegates]. In addition, . . . ‘permitting review only [of] . . . a particular statutory or administrative standard . . . would not result in a costly flood of litigation, because the validity of a standard can be readily established, at times even in a single case.’” *Bowen*, 476 U.S. at 680 n.11 (citation omitted).

and individual appeals of particular reimbursement determinations, which the Court recognized in *Bowen*.

The suggestion that Medicaid providers need not be reimbursed in accordance with the congressionally-mandated standards because provider participation is voluntary and a dissatisfied provider may withdraw⁴⁴ is equally groundless. For approximately half of the hospitals participating in Virginia’s Medicaid program this is not even theoretically a legal possibility because they have received funds under the Hill-Burton Act, 42 U.S.C. §§ 291 *et seq.*, J.A. 17-18, which obligates them to participate in Medicaid.⁴⁵ Furthermore, all hospitals with emergency rooms that participate in Medicare are obliged by federal statute to provide emergency treatment to all persons, including Medicaid patients. See 42 U.S.C. § 1395dd (1988). To the extent that the option of withdrawal from participation exists, this self-help “remedy” is an inappropriate check on state non-compliance. Relying on provider withdrawal to enforce the Act’s requirements would directly contradict the intent of Congress that “payment levels . . . be set at a level that *ensures* the active treatment of Medicaid patients in a majority of the hospitals available in the State,” H.R. Rep. No. 158, *supra*, at 293. The policy of the Act is strongly to encourage provider participation, not to drive them away through arbitrary or inadequate payment rates. See *Illinois Hosp. Ass’n v. Illinois Dep’t of Public Aid*, 576 F. Supp. 360, 372 (N.D. Ill. 1983).

⁴⁴ Pet. Br. 17 n.9; Conn. Amicus Br. 3.

⁴⁵ “Although the [Medicaid] Act itself contains no requirement that hospitals participate in the Medicaid program, hospitals that have accepted federal construction funds under the federal Hill-Burton programs *are* required to participate in the Medicaid program. . . . None of [these] hospitals have the option of terminating its participation in the Medicaid program.” *Illinois Hosp. Ass’n v. Illinois Dep’t of Public Aid*, 576 F. Supp. 360, 366 (N.D. Ill. 1983).

In the final analysis, the defendants' disagreement is with Congress, not with the federal courts that since 1969 have recognized providers' § 1983 cause of action. Congress could have enacted a statute, pledging billions of dollars in federal matching funds, under which the state was under no duty to conform its use of those funds to the statute's standards. Congress could have required the Secretary to continue to engage in direct and intense review of state plans. Congress could have expressly rejected federal litigation over this subject. But Congress did none of these things. Congress chose instead to require states participating in Medicaid to reimburse providers at the level established by the statute. Any decision to rescind the right to receive such reimbursement is a decision that should be made by Congress. As long as the right exists, state and federal courts are empowered to enforce it in actions brought under § 1983.

CONCLUSION

The judgment of the court of appeals below was correct and should be affirmed.

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APPENDIX

Federal Statutory Provisions

42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. III 1985) provides as follows:

A state plan for medical assistance must provide for payment (except where the State agency is subject to an order under section 1396m of this title) of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State which, in the case of nursing facilities, take into account the costs of complying with subsections (b) (other than paragraph (3)(F) thereof), (c), and (d) of section 1396r of this title and provide (in the case of a nursing facility with a waiver under section 1396r(b)(4)(C)(ii) of this title) for an appropriate reduction to take into account the lower costs (if any) of the facility for nursing care, and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs and provide, in the case of hospital patients receiving services at an inappropriate level of care (under conditions similar to those described in section 1395x(v)(1)(G) of this title), for lower reimbursement rates reflecting the level of care actually received (in a manner consistent with section 1395x(v)(1)(G) of this title)) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality; and such State makes further

assurances, satisfactory to the Secretary, for the filing of uniform cost reports by each hospital, nursing facility, and intermediate care facility for the mentally retarded and periodic audits by the State of such reports.

Former 42 U.S.C. § 1396a(a)(13)(D)(i) (1976) provided as follows:

A State plan for medical assistance must provide for payment (except where the State agency is subject to an order under section 1914) of the reasonable cost of inpatient hospital services provided under the plan, as determined in accordance with methods and standards, consistent with section 1122, which shall be developed by the State and reviewed and approved by the Secretary and (after notice of approval by the Secretary) included in the plan, except that the reasonable cost of any such services as determined under such methods and standards shall not exceed the amount which would be determined under section 1861(v) as the reasonable cost of such services for purposes of title XVIII, except that in the case of hospitals reimbursed for services under part A of title XVIII in accordance with section 1814(b)(3), the plan must provide for payment of inpatient hospital services provided in such hospitals under the plan in accordance with the reimbursement system used under such section.

42 U.S.C. § 1396a(a)(37)(1982) provides as follows:

A state plan for medical assistance must provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such claims are paid within 60 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review,

including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program.

Federal Regulations

42 C.F.R. § 447.253(b)(1)(i) (1988) provides that:

Whenever the Medicaid agency makes a change in its methods and standards, but not less often than annually, the agency must make the following findings:

The Medicaid agency pays for inpatient hospital services and long-term care facility services through the use of rates that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations, and quality and safety standards.

42 C.F.R. § 447.253(c)(1988) provides as follows:

The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

State Statutes

Va. Code § 9-6.14:16(B) (Repl. Vol. 1989) provides as follows:

The provisions of this article shall apply to case decisions regarding the grant or denial of aid to dependent children, Medicaid, food stamps, general relief, auxiliary grants, or state-local hospitalization. However, no appeal pursuant to this article may be brought regarding the adequacy of standards of need and payment levels for public assistance programs. Notwithstanding the provisions of § 9-6.14:17, such review shall be based solely upon

the agency record, and the court shall be limited to ascertaining whether there was evidence in the agency record to support the case decision of the agency acting as the trier of fact. If the court finds in favor of the party complaining of agency action, the court shall remand the case to the agency for further proceedings. The validity of any statute, regulation, standard or policy, federal or state, upon which the action of the agency was based shall not be subject to review by the court. No intermediate relief shall be granted under § 9-6.14:18.

Va. Code § 32.1-325.1 (Cum. Supp. 1989) provides as follows:

A. The Director shall make an initial determination as to whether an overpayment has been made to a provider in accordance with the state plan for medical assistance, the provisions of § 9-6.14:11 and applicable federal law. Once a determination of overpayment has been made the Director shall undertake full recovery of such overpayment whether or not the provider disputes, in whole or in part, the initial determination of overpayment. Interest charges on the unpaid balance of any overpayment shall accrue pursuant to § 32.1-313 from the date the Director's determination becomes final. Nothing in § 32.1-313 shall be construed to require interest payments on any portion of overpayment other than the unpaid balance referenced herein. In any case in which an initial determination of overpayment has been reversed in a subsequent agency or judicial proceeding, the provider shall be reimbursed that portion of the payment to which he is entitled plus any applicable interest.

B. An appeal of the Director's initial determination concerning provider reimbursement shall be heard in accordance with the Administrative Process Act (§ 9-6.14:1 et seq.) and the state plan for medical assistance provided for in § 32.1-325. Court review of final agency determinations concerning provider reimbursement shall be made in accordance with the Administrative Process Act. This

provision shall apply to all administrative appeals pending as of its effective date in which no agency hearing has been held.

State Regulation

Section VI of the Virginia State Plan Under Title XIX of the Social Security Act, Attachment 4.19A, "Methods and Standards for Establishing Payment Rates—In-patient Hospital Care" (effective date 9/1/88) provides as follows:

In accordance with Title 42 §§ 447.250 through 447.272 of the *Code of Federal Regulations* which implements § 1902(a)(13)(A) of the *Social Security Act*, the Department of Medical Assistance Services ("DMAS") establishes payment rates for services that are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities to provide services in conformity with state and federal laws, regulations, and quality and safety standards.

FOR ARGUMENT

No. 88-2043

Supreme Court U.S.
Petition for Review
F.I.L.E.D.
JAN 2 1989
JAN 2 1990
JOSEPH F. ANOL, JR.
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

GERALD L. BALILES, et al.,

Petitioners.

v.

THE VIRGINIA HOSPITAL ASSOCIATION.

Respondent.

On Writ of Certiorari To the United States
Court of Appeals For the Fourth Circuit

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REPLY BRIEF OF PETITIONERS

The issue in this case is whether the Boren Amendment, Section 1396a(a)(13)(A) of the Medicaid Act as amended by § 2173(a) of the Omnibus Reconciliation Act of 1981, P.L. 97-35, gives Medicaid providers "enforceable rights" within the meaning of 42 U.S.C. § 1983 (1981) ("Section 1983") to payments by the states that are "reasonable and adequate" to meet the costs they actually incur in serving Medicaid patients. Both the existence of a right and the lack of foreclosure by a Congressionally preferred remedial scheme are essential prerequisites to the assertion of a right of action under Section 1983. Neither of these prerequisites has been met in this case.

ARGUMENT

I. THE BOREN AMENDMENT CREATES NO SUBSTANTIVE FEDERAL RIGHTS

The Respondent, Virginia Hospital Association ("the VHA"), argues alternately that, as amended by the Boren Amendment, Section 1396a(a)(13)(A); (l) gives Medicaid providers the right to "reimbursement

rates that are 'reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities,'" Resp. Br. 4; (2) creates "a federal right on behalf of providers to be paid at rates which are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities," Resp. Br. 16; and (3) sets forth a requirement that "states participating in Medicaid . . . reimburse providers at the level established by the statute," Resp. Br. 46. In fact, Section 1396a(a)(13)(A) says and does none of those things.

As amended, Section 1396a(a)(13)(A) provides in pertinent part that a state plan for medical assistance must provide

for payment . . . of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality. . . .

By its terms, at most, this language requires only that participating states make *findings* that their reimbursement rates are sufficient to assure reasonable access to quality care and provide *assurances* satisfactory to the Secretary that they have done so.

To create secured and enforceable rights within the meaning of Section 1983, a statute must do more than state a "general prohibition or command" to be implemented by a state or federal agency, *University Research Ass'n. v. Contu*, 450 U.S. 754, 772 (1981).¹ It must confer

¹ Purporting to find in Section 1396a(a)(13)(A) "the imposition of binding obligations" Resp. Br. 17, quoting *Pennhurst*, 451 U.S. at 27, the VHA notes that under the statute "[a] state plan for medical assistance *must* provide for payment . . . of the hospital . . . services . . ." Resp. Br. 13 (emphasis added). Like the Court of Appeals, see Pet. App. A7-A8, the VHA evidently believes that, by using the word "must," the statute effectively imposes mandatory obligations on the states, thus ensuring providers a "federal right . . . to be paid at rates which are reasonable and adequate." Resp. Br. 16. But the word "must" is not used in a vacuum. In this case, the word "must" introduces a clause that informs the states that to qualify for federal funds they must pay Medicaid providers using rates that the states find are reasonable and adequate to assure Medicaid recipients access to quality care. The word "must" does not, however, direct the states to pay any particular amount for services or to pay amounts providers deem to be reasonable. Yet, that is precisely what the VHA seeks.

"specific and definite" benefits, *Wright v. Roanoke Redevelopment & Housing Authority*, 479 U.S. 418, 432 (1987), in "right- or duty-creating language." *Cannon v. University of Chicago*, 441 U.S. 677, 690 n.13 (1979). Where, as here, the language does no more than compel a participating state to provide assurances, satisfactory to the Secretary, that it has made certain findings regarding the rates it pays Medicaid providers, there are no benefits conferred or enforceable rights created.² If a statute "confers no substantive rights, [the Court] need not reach the question whether there is a private cause of action under that [statute] or under 42 U.S.C. § 1983 to enforce those rights." *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 28 n.21 (1981), citing *Southeastern Community College v. Davis*, 442 U.S. 397, 404 n.5 (1979).

The language of the Boren Amendment serves the specific purpose of providing medical care to the needy, the only true purpose of the Medicaid program. 42 U.S.C. § 1396 (1985) (the purpose of the Medicaid Act is to enable each state as far as practicable under the conditions in such state to furnish health care to needy persons). To achieve this purpose, the Boren Amendment gives states the flexibility to determine what rates, within the context of state-specific health care cost environments, would be reasonable to meet the purpose of the program.

Beyond making assurances satisfactory to the Secretary that it has made such a determination (or "finding"), a participating state has no obligation under the Boren Amendment. Of course, the Secretary could and does seek further assurances if the assurances provided are not satisfactory to him, based on his own review of the assurances or his review of comments submitted by entities such as provider representatives. Nonetheless, nothing in the Boren Amendment can be construed

² The Boren Amendment is not phrased in terms of the interests of providers as the VHA agrees is required. Resp. Br. 24. Unlike the Housing Act Amendments at issue in *Wright*, which guaranteed tenants in Housing and Urban Development financed projects rents not exceeding "one-fourth of the family's income," 479 U.S. at 420 n.2, the Boren Amendment to the Medicaid Act removed the federal guarantee of reasonable cost reimbursement for providers and substituted, instead, state determined rates designed to effect cost-savings by requiring providers to "manage efficiently in order to remain in business." Statement of Honorable David L. Boren, U.S. Senator from the State of Oklahoma, Medicaid and Medicare Amendments: Hearings on H.R. 4000 (and All Similar Bills) Before the Subcommittee on Health and the Environment of the House Committee on Interstate and Foreign Commerce, 96th Cong., 1st Sess. 846 (1979) ("Boren Testimony").

to establish a right of sufficient specificity to be viewed as an enforceable right under Section 1983.³

The VHA acknowledges that the Commonwealth has made the findings required by the Boren Amendment and has given assurances satisfactory to the Secretary. Nonetheless, the VHA claims a violation of the Act “despite the assurances and findings of the Commonwealth of Virginia and the approval of the Secretary of Health and Human Services.” J.A. 11 (Complaint ¶ 12) (emphasis added). What the VHA really seeks, then, is a right to be paid at rates which *the VHA*, not the State or the Secretary, believes to be reasonable.

The VHA’s characterization of the statutory language ignores the text and reads out of the statute the measure of adequacy and reasonableness Congress explicitly provided: the existence of reasonable access to quality care and services for Medicaid recipients. Instead, the VHA seeks to substitute a financial standard for judging the reasonableness of rates — a standard that looks not to the adequacy and quality of services provided to recipients but to any disparity between payment rates and the costs reportedly incurred by efficient providers. There is no basis in the statute for such a claim.⁴

Rather than guaranteeing “economically and efficiently operated facilities” a *right* to reimbursement of the costs they actually incur in providing services as the VHA argues, the language of the Boren Amendment requires each participating state to make findings and provide assurances to the Secretary that the rates provided in its state plan do not exceed the rates necessary to “meet the costs which *must be incurred*” by efficiently run facilities in order to provide the level of care

³ This Court left open in *Pennhurst* the question whether a statutory provision requiring “assurances” can ever be held to create an enforceable right under Section 1983. 451 U.S. at 28. Of course, this question need not be resolved in this case, as the subject of the assurances here is too indefinite to find an enforceable right even if assurances could give rise to a Section 1983 cause of action in and of themselves.

⁴ As this Court noted in *Pennhurst*, “legislation enacted pursuant to the spending power is much in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions.” 451 U.S. at 17. “The legitimacy of Congress’ power to legislate under the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the ‘contract.’” *Id.* In agreeing to participate in the Medicaid program, the Commonwealth of Virginia accepted the terms of the statute, including the requirement in Section 1396a(a)(13)(A) that it make appropriate findings and give appropriate assurances to the Secretary. The VHA now proposes to change the terms of the contract, by replacing the agreed-to system of findings and assurances with a system of rates that *it* believes (or that it can convince a federal court to believe) are reasonable. The Commonwealth did not enter into such a contract.

and quality of services legally required for Medicaid patients. (Emphasis added.) Thus, the language of the Boren Amendment confers on the states the discretion to review the actual costs incurred by providers and to establish rates that compensate providers *only* for those costs linked to required care and services and, then, *only* at the rate necessary to assure recipient access to services.⁵

The Amendment does not guarantee providers the right to any particular level of payment. To the contrary, the purpose of the Boren Amendment was to encourage the states to establish payment rates based on findings regarding the costs that would be incurred by an “ideal” efficient and economic provider. The intent was to *force* efficiencies and permit states to introduce the law of supply and demand into the Medicaid system.⁶

⁵ In a colloquy on the Senate floor at the time the 1980 Boren Amendment was under consideration, Senator Boren described the effect of the Amendment as follows:

[T]his amendment permits and encourages States to develop simpler more efficient ways of paying for nursing home care, including budget-based and negotiated rates. While it provides for the continuation of cost-reporting and auditing requirements for accountability, the amendment will not require States to rely exclusively on provider cost data in determining rates. Other independent measures of what services ought to cost could be used.

126 Cong. Rec. 17,885 (1980).

⁶ Senator Boren testified in favor of the 1980 Boren Amendment applicable to nursing home rates that:

Federal regulations issued under [the pre-1980 statutory reimbursement provision] require that Medicaid rates be established directly on the basis of actual costs reported by nursing homes. The target of my amendment is this total dependence of the ratesetting system on cost reporting by the providers. Such a system gives no consideration to its effects on provider behavior and insufficient consideration as to whether reported costs are a proper reflection of what services ought to cost in view of other factors, including supply and demand.

To be sure, provider costs data comprise an important element of information in the ratesetting process. Under my amendment, States would continue to have access to that information as provided by various sections of the Social Security Act, including the Fraud and Abuse Control Amendments of 1977. A State would, however, be free to determine the degree to which it would rely on reported costs as a factor in ratesetting together with other relevant factors.

Boren Testimony at 846.

The VHA argues this case as if nothing much happened to Section 1396a(a)(13)(A) in 1980 and 1981. The VHA takes no account of the revised language of the Boren Amendment, nor does it explain how a statute that speaks only of "findings" and "assurances" can be converted into one that affords "a federal right on behalf of providers to be paid at rates which are reasonable and adequate to meet the costs incurred by efficiently and economically operated facilities." Resp. Br. 16. Moreover, the VHA is cavalier about the legislative history of the 1980 and 1981 amendments. In its view, the Boren Amendment — rather than working "a significant change in the federal [reimbursement] standard," *Wisconsin Hospital Ass'n v. Reivitz*, 733 F.2d 1226, 1228 (7th Cir. 1984), designed to give "the States flexibility and discretion . . . to formulate their own methods and standards of payment," S. Rep. No. 471, 96th Cong., 1st Sess. 28-29 (1979) — was essentially a continuation of past practice, reflecting, as the VHA puts it, "Congress's unchanged intention to require states to pay providers in accordance with the (now revised) statutory standards." Resp. Br. 13.⁷

Only by ignoring the fundamental change made by the Boren Amendment can the VHA make the arguments it does. The VHA relies heavily on a series of lower court decisions permitting private actions to enforce earlier versions of Section 1396a(a)(13)(A). Resp. Br. 7-9, 15 n.18.⁸ It also cites 1975 legislation requiring participating states to waive their Eleventh Amendment immunity, as well as the 1976 provision repealing that waiver. Resp. Br. 10-11. But even if those authorities recognized an underlying Section 1983 cause of action — an assertion the Commonwealth disputes — the fact remains that the Boren Amendment explicitly, deliberately and substantially altered the basic statutory framework applicable to Medicaid payment systems.⁹

The VHA finds it "puzzling" that the United States, as *amicus curiae*, contends that Section 1396a(a)(13)(A) "does not require that rates be reasonable and adequate." Resp. Br. 14-15 n.17. The source of the VHA's puzzlement, however, is once again its failure to distinguish between the pre-1980 statute, under which rates had to reflect "reasonable cost," and the statute as amended, under which the states need only make "findings" that their rates are reasonable to assure access to needed services and quality care and give "assurances" satisfactory to the Secretary.

The VHA offers no evidence, however, that Congress considered or approved any of the lower court decisions that it cites.

The VHA contests the "bold assertion" of the United States that "some (unspecified) changes in the statutory language in the 1981 revision [in Section 1396a(a)(13)(A)] silently took away providers' right to sue." Resp. Br. 28. The "changes" in the statute —

(Continued on next page.)

As the Commonwealth and its amici explained at length in the opening briefs, the Boren amendments of 1980 and 1981 expressly revised Section 1396a(a)(13)(A) to eliminate a substantive requirement of "reasonable cost" reimbursement, and to replace it with the present formulation permitting states to make their own findings and assurances to the Secretary regarding the reasonableness and adequacy of payment rates in assuring reasonable access to quality care. That was a dramatic change in the legal landscape, designed intentionally to effect "more stringent cost containment," while freeing the states from excessive "federal oversight of [their] reimbursement methodologies." *Wisconsin Hospital Ass'n v. Reivitz*, 733 F.2d at 1228.

II. THE ADMINISTRATIVE AND JUDICIAL REMEDIES IN THE MEDICAID ACT WERE INTENDED TO FORECLOSE PRIVATE ENFORCEMENT

A. Private enforcement of the Boren Amendment under Section 1983 is inconsistent with and destructive of the carefully tailored Medicaid scheme enacted by Congress.

The VHA argues that the Commonwealth has not met its burden of showing that Congress has foreclosed a Section 1983 remedy by creating a "comprehensive" alternative remedial scheme. Resp. Br. at 30-36. The VHA misconstrues the burden on the Commonwealth. We acknowledge the need to show foreclosure, Pet. Br. at 22-26, but dispute the VHA's contention that an intent to foreclose can only be found where Congress essentially has duplicated, in the statute in question, all of the remedies available under Section 1983.

Congressional intent to foreclose necessarily must be determined in the context of the underlying Congressional purpose of the statutory scheme under review and the nature of the federal right sought to be

(Continued from previous page.) hardly "unspecified" — were the addition of the Boren Amendment language, altering Section 1396a(a)(13)(A) from a "reasonable cost" mandate to a mandate of "findings" and "assurances." The VHA recognizes the change in the law, Resp. Br. 28-29 n.28, but somehow concludes that "a comparison of the provider reimbursement provisions in its 1972 and 1981 forms," Resp. Br. 28, demonstrates that nothing much happened for purposes of Section 1983 lawsuits. We do not understand — and the VHA does not explain — why the availability of a Section 1983 claim should not reflect the substantial overhaul in the underlying statutory right.

enforced.¹⁰ If a remedy were accorded a significance exceeding that of the right it is intended to protect, Congress' careful evaluation of the various competing interests, reflecting its legislative intent in creating a "right," would be ignored in defining the appropriate manner to enforce that wholly statutorily-derived right.¹¹

Section 1983 "is a statutory remedy and Congress retains the authority to repeal it or replace it with an alternative remedy. The crucial question is what Congress intended." *Smith v. Robinson*, 468 U.S. 992, 1012 (1984) (citations omitted)(emphasis added). In reviewing Congressional intent, the critical question is whether private enforcement pursuant to Section 1983 would be inconsistent with a "carefully tailored scheme" enacted by Congress. *Id.* The test is not whether Congress has effectively duplicated the Section 1983 remedy elsewhere, but whether what Congress *has done* is sufficient to show an intent to foreclose private resort to federal courts under that Section. *Middlesex County Sewerage Authority v. National Sea Clammers' Ass'n*, 453 U.S. 1, 20 (1981).

If private Section 1983 enforcement would impair or work at cross purposes with the provisions of the Medicaid Act, such a remedy should not be available to enforce that Act. *Wright v. Roanoke Redevelopment & Housing Authority*, 479 U.S. at 423, citing *Smith v. Robinson*, 468 U.S. 992, 1012 (1984). Moreover, a broadly defined statutory standard should suggest Congressional intent to commit enforcement of

¹⁰ Amicus Temple University, while acknowledging that the Boren Amendment does not require courts to engage in an independent determination of what Medicaid rates should be, suggests nonetheless that the Boren Amendment permits hospitals to challenge "arbitrary and capricious" payment systems. Assuming, arguendo, that the purpose of the Boren Amendment is to prevent states from establishing payment systems which are arbitrary and capricious, Congress' delegation of authority to the Secretary to review state payment systems is a logical and sufficient scheme to ensure a remedy for arbitrary state actions.

¹¹ The Medicaid program is a comprehensive political and legal framework for administration of a major national welfare scheme. Hospital reimbursement is one portion of a larger whole. Whatever affects one class of providers inevitably impacts the others. Litigation by one set of providers pursuing their unique and competing interests will negate the delicate balances struck by the states in fashioning their Medicaid programs. Diversion of limited state revenues to pay attorneys' fees for successful litigants inevitably will force cuts in the services provided for recipients. See 127 Cong. Rec. 19,097 (1981) (remarks of Senator Bradley) (the Boren Amendment "will allow [States] to achieve cost savings without imposing devastating cuts on the recipients of Medicaid services").

that standard to the exclusive discretion of the responsible administrative agency.¹²

The underlying purpose of the Boren Amendment was to give states the flexibility to determine payment rates that would assure continued access to quality care for recipients and to eliminate the inherently inflationary cost-based reimbursement system that preceded it. H.R. Rep. No. 158, 97th Cong. 1st Sess. 293 (1983). Congress provided that "the Secretary retains final authority to review rates and to disapprove these rates if they do not meet the requirements of the statute." H.R. Conf. Rep. No. 1479, 96th Cong. 2nd. Sess., reprinted in 1980 U.S. Code Cong. & Admin. News 5903, 5944. At the same time, while Congress intended to assure state flexibility by limiting federal oversight of state payment systems, it was careful to provide that "the Secretary is not expected to approve a rate lower than the applicable legal requirements would mandate." *Id.* In defining those requirements, Congress explained that, since the Boren Amendment would free states from paying rates based on Medicare principles, the Secretary would only be expected to compare "aggregate amounts paid to hospitals." S. Rep. No. 139, 97th Cong. 1st Sess., reprinted in 1981 U.S. Code Cong. & Admin. News 396, 744-5. To permit individual private challenges to state payment systems would undermine the "aggregate test of reasonableness" which Congress intended to promote with the Boren Amendment. *Id.* at 745.

Consonant with the goals represented by the enactment of the Boren Amendment — state flexibility tempered by Secretarial oversight — Congress required states to submit their payment systems, in the form of state plan amendments, to the Secretary for approval and has given to the states the exclusive right to seek federal judicial review of state plan amendment disapprovals, as well as disallowances of federal matching funds by the Secretary. See 42 U.S.C. § 1315 (1983).

¹² Indeed, this Court has recognized in analogous circumstances that, where a statute provides no substantive standard upon which a court could base its review and "exudes" deference to the administrative agency charged with enforcing the statute, the language "strongly suggests that its implementation was committed to agency discretion by law" and forecloses "any meaningful judicial standard of review." *Webster v. Doe*, 486 U.S. 592, ____ , 100 L.Ed.2d 632, 643 (1988) (statutory provision allowing agency director to terminate employee when he "deem[ed]" such action "necessary and advisable in the national interest" reflects Congressional intent to preclude judicial review under the federal Administrative Process Act, 5 U.S.C. §§ 701-706). The Boren Amendment, which provides that states must "find" that payment rates are "reasonable" and "adequate" enough to ensure access to care, similarly suggests that Congress intended to leave to the Secretary and the states the task of defining reasonableness in this context.

(Section 1116 of the Social Security Act) and the implementing regulations at 42 C.F.R. Part 430 and §§ 430.18 and 430.38 (1988). Furthermore, Congress directed the Secretary to develop an appropriate appeals procedure for health care providers. S. Rep. No. 1240, 94th Cong. 2d Sess., reprinted in 1976 U.S. Code Cong. & Admin. News 5648, 5649-51. In mandating state appeals procedures, the Secretary found that "States are in a better position to define or determine what is 'efficient and economical' for its [sic] Medicaid program. More importantly, we believe *any Federal attempt to impose specific definitions would unnecessarily intrude upon the legislatively mandated flexibility provided to States under the statute.*" 48 Fed. Reg. 56049 (1983) (emphasis added).

Federal administrative monitoring of state plans and state administrative and judicial review of payment systems were intended by Congress as the exclusive means to enforce the Medicaid Act. Particularly in light of the limited nature of the asserted underlying right — at most, a right to "findings" by the State and "assurances" to the Secretary — a system of state administrative and judicial review, coupled with periodic oversight by the Secretary, is entirely sufficient.

B. The VHA describes incorrectly the providers' right to review under the Virginia Administrative Process Act.

The VHA argues that Virginia law does not provide a remedy under which Medicaid providers can litigate reimbursement disputes. Resp. Br. 36-41. That argument is incorrect on its face. The authority cited by the VHA, Resp. Br. at 37, 38 n.34&35, obviously relates exclusively to recipient appeals and to judicial review of eligibility matters. Section 9-6.14:4.1(B)(4) of the Code of Virginia was enacted in 1989 expressly to provide state judicial review of individual eligibility case decisions, a fact the VHA later acknowledges.¹³

Moreover, the VHA ultimately cites Section 32.1-325.1 of the Code of Virginia (Supp. 1989), which was enacted after the decision in *Mary Washington Hospital v. Fisher*, 635 F.Supp. 891 (E.D.Va. 1985), to provide review of provider reimbursement disputes under the Virginia Administrative Process Act, §§ 9-6.14:1 - 9-6.14:25 of the Code of Virginia (1989). Resp. Br. at 38, n.36.

¹³ Respondent's Brief at 35, n.35, discusses this statute at length, acknowledging that it was designed to deal with case decisions regarding the grant or denial of Medicaid benefits. It then suggests inconsistently "[i]f it is [the statute] that provides the basis for judicial review of state plans, . . . meaningful state judicial review would be unavailable."

This statutory process affords to providers, such as the VHA member hospitals, the full panoply of state administrative and judicial review. Acting under its statutory authority, the Virginia Medicaid program has established in the State Plan for Medical Assistance ("State Plan") extensive regulations dealing with hospital reimbursement. J.A. 24-45. This regulatory scheme includes the Prospective Payment System which defines how payments are determined for hospitals, and the Appeals System which provides a detailed procedure for resolution of payment disputes. Under the Appeals System, upheld in 1986 by the District Court in *Mary Washington, supra*, and again by the District Court in this case below, three distinct levels of administrative review are available.¹⁴

Thereafter, two levels of judicial review — to the Virginia circuit courts and to the Virginia Court of Appeals — are available as a matter of right. A third — to the Supreme Court of Virginia — is available by writ. Moreover, the Virginia Administrative Process Act, and § 9-6.14:17 of the Code of Virginia (1989) in particular, assures that the broadest range of factual and legal issues may be heard by the courts of the Commonwealth. These include constitutional, statutory, procedural and factual issues. Issues of federal, as well as state law, may be preserved and raised by providers on appeal whether or not the agency itself has the authority to address them.¹⁵

III. A PRIVATE ACTION TO ENFORCE THE BOREN AMENDMENT IS NOT NECESSARY TO ENSURE THE INTEGRITY OF THE MEDICAID SYSTEM OR THE REASONABLENESS OF REIMBURSEMENT RATES

The VHA contends that, unless the Boren Amendment is construed to afford an enforceable right for providers to reasonable rates, the states will be left "free to pay any amount they choose," thus rendering the statute "meaningless." Resp. Br. 18. That is not so. The premise of the Boren Amendment was that adequate rates could be most efficiently

¹⁴ On October 24, 1989, the District Court once again granted summary judgment to the Commonwealth as to the Appeals System. The ruling was made from the bench and an order has not yet been formally entered.

¹⁵ See e.g., *Bridgewater Home, Inc. v. Commonwealth of Virginia* (Va. App. Rec. No. 0888-87-4, July 22, 1988), a Medicaid provider dispute raising both federal and state issues.

secured by freeing the states from excessive federal scrutiny, which had “overburden[ed] the States and facilities with marginal but massive paperwork requirements.” S. Rep. No. 471, *supra*, at 29. The idea was to promote state accountability — by requiring the *states* to find, and satisfactorily assure the *Secretary*, that their rates were sufficient.¹⁶ That is one way — a reasonable and sensible way — of promoting Congress’ goals in the Medicaid statute. The VHA offers another way, private suits to reexamine the absolute reasonableness of rates, but it is not the way chosen by Congress.¹⁷ And, the VHA’s professed concern about the efficacy of Congress’ choice — that a state may decide “without limit, simply [to] adopt any reimbursement method it chose, and pay as little as it wished,” Resp. Br. 18 — reflects a suspicion of state integrity and commitment to quality care that is not warranted by the record and, in

¹⁶ We do not understand the VHA’s suggestion, Resp. Br. 19, that we and the United States as amicus have somehow “ignore[d] the fact that the statute expressly requires, before any assurances are made to the Secretary, that a state find that its plan will produce reasonable and adequate rates.” We recognize the obligation to make such findings and the VHA acknowledges that the Commonwealth has made the required findings in this case; our point, however, is that the obligation to make findings does not convert into an enforceable obligation to pay rates that providers believe to be reasonable.

¹⁷ The VHA relies, Resp. Br. 16, 22, on this Court’s recent decision in *Golden State Transit Corp. v. City of Los Angeles*, No. 88-840, slip. op. (Dec. 5, 1989), but that case affords cold comfort. In *Golden State*, the Court held that an employer could sue under Section 1983 for damages arising from a city’s interference with its statutory rights under the National Labor Relations Act. The Court reasoned, from the text of the statute and the decisions construing it, that the NLRA was designed “to give parties to a collective-bargaining agreement the right to make use of ‘economic weapons.’ . . . free from governmental interference.” *Id.* at 8. The Court concluded that “the interest in being free of governmental regulation of the ‘peaceful methods of putting economic pressure upon one another.’ . . . is a right specifically conferred on employers and employees by the NLRA.” *Id.* at 9. It therefore held that the Act created “obligations ‘sufficiently specific and definite to be within the competence of the judiciary to enforce.’” *Id.* at 9.

Golden State is easily distinguishable. “[B]ased on the language, structure, and history of the NLRA,” *id.* at 8, the Court found a well-demarcated zone of labor-management dispute within which government (federal and state) may not interfere. The terms of the right were clear-cut: provided the parties to a labor dispute use lawful “economic weapons,” they are entitled to a regime of strict noninterference. *Id.* By contrast, the underlying right established by Section 1396(a)(13)(A) is anything but “specific and definite.” See *id.* at 5. At most, it entitles providers to insist on findings and assurances — obligations that the VHA concedes have been sacrificed in this case.

any event, is not consistent with the Congressional design.¹⁸ Senator Boren rejected this kind of argument as “simply fatuous.” Boren Testimony at page 847, and so should this Court.

CONCLUSION

For all of the reasons stated, the Commonwealth respectfully requests that the Court reverse the decision of the Court of Appeals.

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¹⁸ For the same reason, the VHA errs in contending that it is “irrelevant,” under our view of the statute, “[w]hether [the state’s] ‘assurances’ are true or false.” Resp. Br. 19. No one is suggesting that a state is entitled to shirk its duty to make appropriate findings or to give honest assurances to the Secretary. The question presented, however, is whether a statutory scheme that explicitly rests on a system of findings and assurances thereby creates enforceable rights in private parties under Section 1983. For the reasons we have stated, the answer is plainly no.

NOV 16 1989

JOSEPH F. SPANIOL, JR.
CLERK

No. 88-2043

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In the Supreme Court of the United States**OCTOBER TERM, 1989****GERALD L. BALILES, ET AL., PETITIONERS****v.****THE VIRGINIA HOSPITAL ASSOCIATION****ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE FOURTH CIRCUIT****BRIEF FOR THE UNITED STATES
AS AMICUS CURIAE SUPPORTING PETITIONERS****KENNETH W. STARR**
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QUESTION PRESENTED

Whether a health care provider may bring an action under 42 U.S.C. 1983 to challenge a State's Medicaid plan on the ground that it fails to provide "reasonable and adequate" reimbursement, in purported violation of 42 U.S.C. 1396a(a)(13)(A) (1982 & Supp. III 1985).

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In the Supreme Court of the United States

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v.

THE VIRGINIA HOSPITAL ASSOCIATION

*ON WRIT OF CERTIORARI TO THE UNITED STATES
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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONERS

INTEREST OF THE UNITED STATES

Medicaid is a cooperative federal-state program “providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons” (*Harris v. McRae*, 448 U.S. 297, 301 (1980)). In developing plans for administering the Medicaid program, States are given considerable discretion in determining who will receive Medicaid assistance and what kinds of assistance will be provided. State Medicaid plans, however, must comply with requirements imposed by the Act and by the Secretary of Health and Human Services. 42 U.S.C. 1396a (1982 & Supp. III 1985).

In this case, the court of appeals held that an association of health care providers may bring an action under 42 U.S.C. 1983 to challenge a State’s alleged failure to pro-

vide sufficient Medicaid reimbursement, in purported violation of 42 U.S.C. 1396a(a)(13)(A) (1982 & Supp. III 1985). The United States has a significant financial stake in the disposition of that issue. By law, the federal government provides between 50% and 83% of the cost of patient care, as determined by a formula keyed to per capita income of the State. See 42 U.S.C. 1396d(b) (1982 & Supp. III 1985). In fiscal year 1988 alone, the federal contribution to the Medicaid program for medical assistance totalled approximately \$29 billion, making Medicaid one of the largest items in the federal budget.¹ Beyond this, the federal government makes at least a 50% contribution to the States' administrative expenses under the Medicaid program—including the cost of defending actions, like this one, for purported violations of the Social Security Act. See 42 U.S.C. 1396b(a)(7). In fiscal year 1988, the United States covered approximately \$1.51 billion of state administrative costs.²

The United States also has a substantial interest in the particular legal question presented here. Regulations promulgated by the Secretary to implement the Medicaid statute require States to establish procedures that afford providers an opportunity to challenge reimbursement decisions. See 42 C.F.R. 447.253(c). Under the court of appeals' decision, however, state administrative procedures may be bypassed entirely, in favor of a federal court action under Section 1983. That result, if upheld, would have a significant impact on the Medicaid program. It would enable thousands of routine cases like this—involving a claim that a State

¹ Health Care Financing Admin., Dep't of Health and Human Services, *Medicaid Financial Management Report: Fiscal Year 1988* [hereinafter *Medicaid Financial Management Report*]. Of this sum, HHS provided \$399.3 million to the State of Virginia.

² *Medicaid Financial Management Report*. Of this amount, some \$25 million was provided to Virginia.

has failed to make adequate reimbursement to particular health care providers—to be brought in federal court. Such an explosion of litigation would vastly increase the cost of the Medicaid program, to the detriment of both state and federal governments, and to the ultimate detriment of Medicaid recipients.

STATEMENT

1. Congress established the Medicaid program in 1965 "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris v. McRae*, 448 U.S. 297, 301 (1980); see *Atkins v. Rivera*, 477 U.S. 154, 156 (1986); *Schweiker v. Gray Panthers*, 453 U.S. 34, 36 (1981). As a cooperative federal-state program, Medicaid leaves the decision whether to participate to the sole discretion of each State. Once that initial decision has been made, States electing to participate must comply with basic requirements imposed by the Act and by the Secretary of Health and Human Services (see 42 U.S.C. 1396a (1982 & Supp. III 1985); *Rivera*, 477 U.S. at 157; *Gray Panthers*, 453 U.S. at 37). Within those basic limits, however, each State enjoys great flexibility both in administering its program and in deciding what specific provisions its program will contain.

To qualify for federal assistance, participating States must submit to the Secretary, and have approved, "a plan for medical assistance" (42 U.S.C. 1396a(a) (1982 & Supp. III 1985)). Among other things, such a plan must provide (42 U.S.C. 1396a(a)(13)(A) (1982 & Supp. III 1985)):

for payment * * * of the hospital, skilled nursing facility, and intermediate care facility services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State * * *) which the State finds, and makes

assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access * * * to inpatient hospital services of adequate quality * * *.

The Secretary's regulations under this provision require the States to establish an administrative appeals procedure for providers to challenge Medicaid reimbursement decisions. In particular, the regulations mandate that States have an "appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the [state] agency determines appropriate, of payment rates." 42 C.F.R. 447.253(c).

In implementing Section 1396a(a)(13)(A), the Secretary has not provided a national definition or specific criteria for "reasonable and adequate" payment rates or for "efficiently and economically operated facilities." See 48 Fed. Reg. 56,046, 56,049 (1983). The Secretary has, instead, sought to preserve maximum flexibility for the States to respond to the particular and varied circumstances they face (*id.* at 56,048). Accordingly, the Secretary does not set "reasonable and adequate" rates; rather, as provided in the statute, participating States are required to submit assurances to the Secretary that *they* have made findings that their payment rates meet all statutory requirements. 42 C.F.R. 447.253(b)(2).³ The States are not required to

³ The regulations also require that before a State may seek the Secretary's approval of any significant changes in its methods and standards for setting payment rates, it must publish such changes for public

submit to the Secretary the findings themselves or the underlying data and analyses (see 48 Fed Reg. 56,046, 56,050 (1983)); instead, the Secretary examines the States' assurances to determine whether they are "satisfactory" within the meaning of Section 1396a(a)(13)(A). *Id.* at 56,050-56,051. The statute further provides that the States' assurances will be considered satisfactory, in the absence of a formal finding by the Secretary to the contrary. See 42 U.S.C. 1396a(b); 42 C.F.R. 447.256(b).⁴

2. a. The Commonwealth of Virginia has elected to participate in the Medicaid program. Accordingly, Virginia has submitted to the Secretary, and had approved, a plan for medical assistance pursuant to 42 U.S.C. 1396a(a) (1982 & Supp. III 1985). The plan categorizes hospitals into "peer groups," based on their size and location (urban or rural) (J.A. 25). For each group of hospitals, the Commonwealth in 1982 developed, on the basis of available cost data, a median cost of care per Medicaid patient day (*ibid.*). Hospitals were originally reimbursed at the median rate for their "peer group" or at their actual cost (plus a percentage of the difference between their actual cost and the median, as an incentive to stay below the median), whichever was

comment, thus affording providers and other persons an opportunity to influence the rate-setting process. 42 C.F.R. 447.205, 447.253(f). In addition, in order to obtain the Secretary's approval of any change in payment rates, the State must submit an estimate of the average proposed rates for each type of provider, the difference between the proposed rates and the existing rates, and an estimate of the short-term and long-term effects of the proposed rates on the availability of services, the type of care furnished, the extent of provider participation, and the degree to which the proposed rates will cover provider costs in hospitals serving a disproportionate number of low income patients with special needs. 42 C.F.R. 447.255.

* The Secretary may request a State to provide additional background information if he believes it is necessary for a complete review of the State's assurances. 48 Fed. Reg. 56,046, 56,050 (1983).

lower (J.A. 25-26). Subsequently, the median rate became the payment ceiling for each group. Between 1982 and 1986, the ceilings were adjusted for inflation, using a modified national consumer price index (J.A. 12-13). Since 1986, the ceilings have been adjusted using an inflation index specifically based on medical care costs (J.A. 26).

Pursuant to federal requirements, the Virginia plan also creates an administrative appeals procedure for providers who wish to challenge Medicaid reimbursement decisions (J.A. 32-45). The procedure calls for an initial decision by Virginia's Department of Medical Assistance Services, informal review by a Department appeals officer, and a formal administrative hearing before a state hearing officer, who submits proposed findings of fact and conclusions of law to the Director of the Department of Medical Assistance Services (*ibid.*). Pursuant to the state Medicaid statute (Va. Code § 32.1-325.1 (Supp. 1989)), the Director's decision is thereafter reviewable in state court under provisions of the Virginia Administrative Process Act (*id.* § 9-6.14:1 *et seq.* (repl. 1989)). The Commonwealth's Medicaid appeals procedure precludes administrative review of the principles of Medicaid reimbursement under the state plan (J.A. 33), but there is no such specific limitation on the scope of judicial review in the state courts (see Va. Code § 9-6.14:17 (repl. 1989)).

b. Respondent is the Virginia Hospital Association, a trade association representing public and private hospitals in Virginia (J.A. 4-5). Respondent brought this action under 42 U.S.C. 1983 to challenge Virginia's reimbursement rates under the state Medicaid plan. Respondent alleged that the plan systematically undercompensates providers for the costs of caring for Medicaid patients.⁵ In addition, respondent

⁵ In particular, respondent alleged that (1) the use of a general consumer price index to adjust reimbursement rates until 1986 resulted in an underestimation of the actual rate of inflation in medical care costs

alleged that the appeals procedure in the state plan provides an inadequate method for challenging defects in the Medicaid payment system because it excludes challenges to the principles of reimbursement and permits only case-by-case appeals involving the application of those rates to particular providers (J.A. 18-20). Respondent contended that the Virginia Medicaid plan violates 42 U.S.C. 1396a, as well as the providers' due process rights under the Fourteenth Amendment (Pet. App. A4). Respondent sought declaratory and injunctive relief, including an order requiring petitioners to promulgate a new state plan and, in the interim, to reimburse Medicaid providers "at a level commensurate with payment under Title XVIII of the Social Security Act, as amended, commonly known as the Medicare Act" (*ibid.*; J.A. 21-22).

3. After initially dismissing the complaint on collateral estoppel grounds (see Pet. App. A4), the district court, on remand from the court of appeals, denied petitioners' motion for summary judgment. The court held that Section 1396a(a)(13)(A) creates enforceable rights under 42 U.S.C. 1983, distinguishing this Court's decision in *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1 (1981). Pet. App. D5.⁶ The district court certified its decision for interlocutory review (*id.* at D1).

during that period; (2) even after the State adopted an inflation index based on medical care costs, it failed to apply the index properly; (3) adjustment of reimbursement rates solely by application of an inflation index, even one based specifically on medical care costs, failed to take into account other cost factors not related to inflation; and (4) the method of computing "peer group" medians failed to reflect the true impact of inflation on the cost of care, because variations in different hospitals' fiscal years resulted in the application of the inflation index to outdated cost data for many hospitals (J.A. 14-16).

⁶ The district court also held that the Eleventh Amendment does not bar relief in this case; that respondent has standing to bring the action;

4. The court of appeals affirmed (Pet. App. A1-A18), agreeing with the district court that Section 1396a(a)(13)(A) creates enforceable rights under 42 U.S.C. 1983. The court concluded that the language and legislative history of the Medicaid Act “reveal[] an unambiguous intent to assure reimbursement rates that are reasonable and adequate in fact” (*id.* at A7). The court explained that the various requirements for state Medicaid plans are “subject to the imperative of their predicate § 1396a(a), which indicates that the provisions specify what a State plan ‘must’ contain” (*ibid.*). That language, the court surmised, “reveals a congressional intent to condition federal assistance on states’ achievement of the express purpose of the section, and not simply on states’ assurances of compliance” (*id.* at A7-A8).⁷

The court of appeals held that the legislative history of the Medicaid Act confirms the availability of Section 1983 relief. Pet. App. A8-A10. The court explained (*id.* at A8) that certain Conference Committee remarks “make plain that the latitude § 1396a(a)(13)(A) grants States is not willfully to assign reimbursement rates, but flexibly to determine what methods and factors will produce rates adequate

that the remedial scheme adopted by the Medicaid Act does not foreclose a Section 1983 remedy; that the statute of limitations does not bar the action; that the action is ripe for adjudication and is not barred by precedent; and that abstention by the court is unwarranted. Pet. App. D3-D8.

⁷ The court acknowledged that the Secretary’s regulations require him to review only the State’s assurances that its methods and standards for setting payment rates are consistent with federal requirements. It also recognized that the regulations do not require federal review of the reasonableness of the actual reimbursement rates established under the State’s plan. The court concluded, however, that those regulations – far from foreclosing a Section 1983 remedy – confirm that Section 1396a(a)(13)(A) was not intended to displace “federal judicial scrutiny” of the reasonableness of reimbursement rates. Pet. App. A8 n.4.

in fact given the circumstances particular to each State’s hospitals.” Moreover, the court stated, “[t]he legislative history * * * indicates that Congress intended no close scrutiny by the Secretary of Virginia’s assurances of compliance with the mandates of § 1396a(a)(13)(A)” (*id.* at A9). Although the court acknowledged that “a logical reading” of this legislative history might be that Congress intended to “insulate[] State reimbursement programs from challenges by hospitals” (*ibid.*), it rejected that conclusion. Instead, the court inferred, the legislative record demonstrates that state review and assurances to the Secretary were not designed “to be the sole means of assuring that the Virginia system provides reasonable access to care of adequate quality” (*ibid.*).

Finally, the court of appeals held that the enforcement mechanism created by the Medicaid Act is not sufficiently comprehensive to foreclose recourse to Section 1983. Pet. App. A10-A12. The court recognized that, under the Act, the Secretary may review and audit the implementation of State plans, and that he may withdraw federal funds if necessary. The court also noted that various remedies are available under Virginia law to aggrieved Medicaid providers. Relying on this Court’s decision in *Wright v. City of Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418 (1987), however, the court held that those remedies were insufficient to foreclose Section 1983 relief.⁸

SUMMARY OF ARGUMENT

The court of appeals has held that Medicaid providers may bring a Section 1983 action in federal court to challenge

* The court of appeals also held that *stare decisis* and Eleventh Amendment principles do not foreclose the lawsuit; that respondent has standing to sue; that there is no statute of limitations bar; that the action is ripe; and that abstention is unwarranted. Pet. App. A12-A18.

a State's purported failure to comply with Section 1396a(a)(13)(A) of the Medicaid Act. In the court's view, Section 1396a(a)(13)(A) creates enforceable rights for purposes of Section 1983. Looking to the text and history of the Medicaid Act, the court concluded that Section 1396a(a)(13)(A) "reveals a congressional intent to condition federal assistance on states' achievement of the express purpose of the section, and not simply on states' assurances of compliance." Pet. App. A7-A8.

The text of the statute does not justify the court's conclusion. Far from creating the "specific and definite" rights afforded by the legislation at issue in *Wright v. City of Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418, 432 (1987), Section 1396a(a)(13)(A) simply requires States to include in their Medicaid plans provider payments "which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities * * *." As this Court explained in *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1, 28 (1981), "[i]t is at least an open question whether an individual's interest in having a State provide those 'assurances' is a 'right secured' by the laws of the United States within the meaning of § 1983." In any event, the statute by its terms does not require that rates be reasonable and adequate, and there accordingly can be no private right of action in federal court to secure such rates.

The legislative history of Section 1396a(a)(13)(A) confirms that Congress did not intend to create enforceable rights under Section 1983. Section 1396a(a)(13)(A) was amended in 1980, and again in 1981, expressly to free the States from the burdensome oversight of the federal government. It is difficult to believe that Congress – having deliberately insulated state administrative processes from superintendence

by the federal government – would permit the same close monitoring under the aegis of Section 1983 litigation.⁹

ARGUMENT

THE COURT OF APPEALS ERRED IN HOLDING THAT RESPONDENT MAY SUE THE COMMONWEALTH OF VIRGINIA UNDER SECTION 1983 FOR AN ALLEGED VIOLATION OF 42 U.S.C. 1396a(a)(13)(A)

- A. There is no Section 1983 cause of action to enforce a federal statute unless Congress intended the statute to create enforceable rights

1. Under 42 U.S.C. 1983, any person who is deprived "of any rights, privileges, or immunities secured by the Constitution and laws" by a person acting under color of state law may bring a private action to seek redress. In *Maine v. Thiboutot*, 448 U.S. 1 (1980), this Court held that the phrase "and laws" in Section 1983 must be read literally, to create a private cause of action against state officials for violations of rights created by federal statutes. One year after its decision in *Thiboutot*, however, this Court in *Pennhurst* "recognized two exceptions to the application of § 1983 to statutory violations." *Middlesex County Sewerage Auth. v. Nat'l Sea Clammers Ass'n*, 453 U.S. 1, 19 (1981), citing *Pennhurst State School & Hosp. v. Halderman*, 451 U.S. 1 (1981). In particular, the Court held that a Section 1983 action will not lie where (1) Congress has foreclosed private enforcement of the federal statute in the statute itself, or (2) the statute does not create "enforceable rights" under Section 1983. *Sea Clammers*, 453 U.S. at 19; *Pennhurst*, 451 U.S. at 28; see also *Wright v. City of Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418 (1987).

The contours of the "enforceable rights" exception were laid out in *Pennhurst* itself. There, plaintiffs brought an action under the Developmentally Disabled Assistance and

⁹ The argument we present below is substantially similar to the argument we made as amicus curiae in *State of Oregon, Department of Human Resources v. Coos Bay Care Center*, No. 86-1419, vacated as moot, 108 S. Ct. 52 (1987). We have furnished the parties with copies of our brief in that case.

Bill of Rights Act, 42 U.S.C. 6000 *et seq.*, to challenge the conditions at a state-operated facility for the mentally retarded. Plaintiffs relied on several sections of the Act. The first of these, Section 6010 (the so-called “bill of rights” provision), set out a series of “findings respecting the rights of persons with developmental disabilities” (42 U.S.C. 6010 (quoted in 451 U.S. at 13)). The *Pennhurst* plaintiffs also relied on provisions of the statute in question that required participating States, as a condition of the receipt of federal funds, to make “assurances” to the Secretary that they had a habilitation plan in effect for the retarded (Section 6011) and that their programs protected their patients’ human rights (Section 6063(b)(5)(C)).

Rejecting plaintiffs’ claims, the Court in *Pennhurst* held, first, that Section 6010 “does not create substantive rights” and “does no more than express a congressional preference for certain kinds of treatment” (451 U.S. at 11, 19). Rather than imposing “binding obligations on the States,” the Court explained, Section 6010 “spoke merely in precatory terms” and simply offered “congressional ‘encouragement’ of state programs” (451 U.S. at 18, 27). Turning to Sections 6011 and 6063(b)(5)(C) of the Act, which the courts below had not addressed, this Court remanded to the court of appeals for further consideration (451 U.S. at 30). But the Court noted that under those Sections plaintiffs “can only claim that the state plan has not provided adequate ‘assurances’ to the Secretary” (*id.* at 28). “It is at least an open question,” the Court stated, “whether an individual’s interest in having a State provide those ‘assurances’ is a ‘right secured’ by the laws of the United States within the meaning of § 1983” (*ibid.*).

More recently, the Court applied the “enforceable rights” exception in *Wright v. City of Roanoke Redevelopment and Housing Auth.*, 479 U.S. 418 (1987). In that case, tenants living in housing projects owned by a city redevelopment authority brought suit under Section 1983, alleging that the

city had violated a rent ceiling imposed by the Brooke Amendment to the Housing Act of 1937, Pub. L. No. 91-152, § 213, 83 Stat. 389, and implementing HUD regulations. The Court held that the Brooke Amendment did create “enforceable rights,” explaining that the Amendment “could not be clearer” in setting an upper limit on chargeable rents and in establishing “a mandatory limitation focusing on the individual family and its income” (479 U.S. at 430). The Court also stated that the standard set by the Amendment and its accompanying regulations was not “too vague and amorphous to confer on tenants an enforceable ‘right,’” since the Amendment and regulations, taken together, “specifically set out guidelines that the [housing authorities] were to follow” (*id.* at 431-432). The Court accordingly determined that “the benefits Congress intended to confer on tenants are sufficiently specific and definite to qualify as enforceable rights under *Pennhurst* and § 1983” (479 U.S. at 432).

2. In deciding whether a federal statute creates “enforceable rights” under *Pennhurst*, a court must look beyond whether the plaintiffs are among the intended beneficiaries of the particular statute. A statute may intentionally benefit a particular person or class of persons, without creating “specific and definite” rights on their part (*Wright*, 479 U.S. at 432), and without designating them as the appropriate agents to enforce whatever rights exist. See Brown, *Pennhurst As A Source Of Defenses For State And Local Governments*, 31 Cath. U.L. Rev. 449, 459 (1982). As this Court has put it, “[t]he question is not simply who would benefit from the Act, but whether Congress intended to confer federal rights upon those beneficiaries” (*California v. Sierra Club*, 451 U.S. 287, 294 (1981)). In answering that question, a court must look, as this Court did in *Pennhurst* and *Wright*, to the language and history of the statute to discern whether Congress clearly intended to create a

"specific and definite" right and to authorize private enforcement of that right in federal court. Several principles should guide a court's approach.

First and foremost, the language of the statute must be mandatory and specific in order to create an enforceable right. As this Court has explained in a related context, the "right- or duty-creating language of the statute has generally been the most accurate indicator of the propriety of implication of a cause of action" (*Cannon v. University of Chicago*, 441 U.S. 677, 690 n.13 (1979)). The courts must therefore "distinguish statutory provisions that announce broad policy goals or general preferences from those that dictate specifically what the relevant governmental officials may and may not do" (*Edwards v. District of Columbia*, 821 F.2d 651, 656 (D.C. Cir. 1987)). Applying that distinction, "the courts of appeals in the aftermath of *Pennhurst* have, for the most part, upheld rights claims in statutes that dictate specific action and leave little room for choice, while rejecting rights claims in statutes that merely indicate broad preferences" (*ibid.*). This Court itself has explained that a statutory obligation must be "specific and definite" in order to create an enforceable right (*Wright*, 479 U.S. at 432), and the courts of appeals have similarly reasoned that the statute must be "cast in the imperative" (*Alexander v. Polk*, 750 F.2d 250, 259 (3d Cir. 1984)), and must "clearly impose[] an affirmative obligation" (*Polchowski v. Gorris*, 714 F.2d 749, 751 (7th Cir. 1983)).¹⁰

¹⁰ The D.C. Circuit's decision in *Edwards v. District of Columbia*, *supra*, demonstrates, in our view, an appropriate consideration of statutory language in applying the "enforceable rights" exception. Plaintiffs there sued a local public housing agency for its alleged failure to comply with certain conditions imposed by federal law for the demolition of a federally funded housing project. Although the Secretary of HUD had not approved an application to demolish the project, plaintiffs asserted that the statutory conditions on demolition imposed

Second, a court is to consider the nature of the federal standard imposed by the statute. Where, for example, the statute imposes an open-ended standard of "reasonableness," a court should be reluctant to conclude that Congress intended to authorize federal courts to superintend a State's compliance with that standard. See generally Sunstein, *Section 1983 and the Private Enforcement of Federal Law*, 49 U. Chi. L. Rev. 394, 428-430 (1982). Moreover, state administrative agencies, which deal on a day-to-day basis with the intricacies of their own grant programs, are obviously well suited to ascertain what is "reasonable" under all the circumstances, and that fact should make a federal court particularly reluctant to second-guess the State's assessment.

independent duties on the local agency that tenants were entitled to enforce under Section 1983. The court of appeals rejected the claim and ordered dismissal of the complaint. Concluding that the federal housing statute did not create any enforceable rights, the court properly distinguished between "broad policy goals" and mandatory, right-creating provisions (821 F.2d at 656):

While policy goals and general preferences leave much room for governmental officials to determine the means by which these goals and preferences are to be carried out, and therefore are ambiguous regarding what duties are owed to which citizens, specific language of obligation narrowly cabins the discretion of officials, and, by the same terms, secures rights to a specific class of people.

The court reviewed the language and legislative history of the statute and held that the obligations relied on by the plaintiffs were simply conditions precedent to the Secretary's grant of a demolition application; they did not create enforceable obligations independent of the application process.

B. Section 1396a(a)(13)(A) was not designed to create enforceable rights for purposes of 42 U.S.C. 1983¹¹

1. Section 1396a(a)(13)(A) does not read like a statute designed to “dictate specifically what the relevant governmental officials may and may not do” (*Edwards*, 821 F.2d at 656). Far from containing “right- or duty-creating language” (*Cannon v. University of Chicago*, 441 U.S. at 690 n.13), Section 1396a(a)(13)(A) permits participating States to devise reimbursement rates “which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities * * *.” The statute further provides that such rates are to be set “in accordance with methods and standards developed by the State.” By its terms, therefore, Section 1396a(a)(13)(A) vests ratemaking discretion in the States, subject only to the condition that they make “assurances” satisfactory to the Secretary. As this Court explained in *Pennhurst*, “[i]t is at least an open question whether an individual’s interest in having a State provide * * * ‘assurances’ [to the Secretary] is a ‘right secured’ by the laws of the United States within the meaning of § 1983” (451 U.S. at 28).

Moreover, the standard of “reasonableness” set forth in the statute suggests that Congress did not intend the federal courts to monitor the States’ compliance by way of private actions under Section 1983. This Court in *Wright* concluded that the Brooke Amendment and its implementing regulations created enforceable rights because they “specifically

¹¹ Because Section 1396a(a)(13)(A) does not create an enforceable right for purposes of 42 U.S.C. 1983, there is no need for this Court to reach the question whether Congress has created alternative remedies sufficient to foreclose enforcement through 42 U.S.C. 1983. See *Pennhurst*, 451 U.S. at 28; *Middlesex County Sewerage Auth. v. Nat'l Sea Clammers Ass'n*, 453 U.S. 1, 19 (1981).

set out guidelines that the [housing authorities] were to follow in establishing utility allowances” (479 U.S. at 431-432). Here, by contrast, Section 1396a(a)(13)(A) provides in general terms that the State must find, and assure the Secretary, only that its reimbursement rates are “reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws * * *.” The implementing regulations reiterate that broad standard, leaving the States free to structure reimbursement systems tailored to their own objectives.¹² Nowhere in the statute can one find the “specific language of obligation [that] narrowly cabins the discretion of officials, and, by the same terms, secures rights to a specific class of people” (*Edwards*, 821 F.2d at 656). Rather, “[t]he subsection is essentially administrative in nature” (*Polchowski v. Gorris*, 714 F.2d at 751), entrusting to the individual States the duty to define and implement a “reasonable” reimbursement system.

The court below acknowledged that Section 1396a(a)(13)(A) “does not in so many words” require States to provide reimbursement rates that are, in fact, “reasonable and adequate.” Pet. App. A7. It nonetheless divined in the statutory language “an unambiguous intent to assure reimbursement rates” that meet that standard. *Ibid.* The court reasoned that, pursuant to Section 1396a(a), a participating State “must” include certain designated elements in its plan, including the features required by Section 1396a(a)(13)(A). The court surmised that, by using the word “must,” the

¹² Thus, 42 C.F.R. 447.252(a) provides simply that the state plan “must provide that the requirements of this subpart [implementing Section 1396a(a)(13)(A)] are met.” 42 C.F.R. 447.253, which elaborates the requirements for “state assurances” under Section 1396a(a)(13)(A), merely requires state Medicaid agencies to “make * * * findings” that their Medicaid payment rates are “reasonable and adequate.”

statute reflects a “congressional intent to condition federal assistance on states’ *achievement* of the express purpose of the section, and not simply on states’ *assurances* of compliance.” *Id.* at A8 (emphasis added).

The language of the statute cannot be worked so hard. State plans “must,” to be sure, contain each of the provisions listed in Section 1396a(a). But that “imperative” language (Pet. App. A7)—which may, *arguendo*, give rise to a lawsuit challenging a State’s failure to include one of the designated provisions in its plan—has no bearing on respondent’s lawsuit. Respondent does not assert that petitioners’ plan is missing a term; it asserts, rather, that petitioners have not achieved “reasonable and adequate” rates, and it seeks an order requiring petitioners to pay such rates. Under the relevant statutory provision, however, no such “imperative” duty is imposed on the States. To the contrary, pursuant to Section 1396a(a)(13)(A), the state plan need only provide for payment “which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate”—even if the rates that the State pays prove unsatisfactory to a Section 1983 plaintiff.

2. The legislative history of Section 1396a(a)(13)(A) confirms that Congress did not intend, as the court of appeals supposed (Pet. App. A8-A10), to create a right to “reasonable” reimbursement payments enforceable in federal court. To the contrary, the history of the statute reveals that Congress deliberately sought to avoid saddling state reimbursement decisions with cumbersome federal oversight. In view of that history, it cannot plausibly be contended that Congress expected private parties to enforce their own views of appropriate Medicaid rate-setting under the aegis of a Section 1983 action in federal court.

a. In 1972 Congress enacted a “reasonable cost” formula for making Medicaid reimbursements to skilled nursing facilities and intermediate care facilities. Codified at the time

in 42 U.S.C. 1396a(a)(13)(E) (Supp. II 1972), this statute required participating States to include in their Medicaid plans a provision “for payment of the skilled nursing facility and intermediate care facility services provided under the plan on a reasonable cost related basis.” Social Security Amendments of 1972, Pub. L. No. 92-603, § 249(a), 86 Stat. 1426. That provision, linking reimbursement to facilities’ actual costs, “was designed to assure that payment rates would more closely reflect the reasonable costs necessary to provide * * * services of adequate quality” (S. Rep. No. 471, 96th Cong., 1st Sess. 28 (1979)).

In 1979, however, Congress concluded that the “reasonable cost” reimbursement formula was no longer “entirely satisfactory” (S. Rep. No. 471, *supra*, at 28). Congress found that requiring States to adopt that formula had proved to be “inherently inflationary” and “contain[ed] no incentives for efficient performance” (*ibid.*). In 1980, therefore, Congress abandoned the “reasonable cost” reimbursement system and adopted the so-called Boren Amendment, now embodied in Section 1396a(a)(13)(A). Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 962(a), 94 Stat. 2650-2651.¹³

The Boren Amendment “represented a significant change in the federal [reimbursement] standard,” offering the States an opportunity to effect “more stringent cost containment” while freeing them from excessive “federal oversight of [their] reimbursement methodologies” (*Wisconsin Hospital Ass’n v. Reivitz*, 733 F.2d 1226, 1228 (7th Cir. 1984)).

¹³ In 1981, Congress abandoned the “reasonable cost” reimbursement formula for hospitals as well, providing that hospitals, like nursing homes and intermediate care facilities, should be governed henceforth by a revised standard now incorporated in 42 U.S.C. 1396a(a)(13)(A). See Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2173(a), 95 Stat. 808. See generally *Wisconsin Hospital Ass’n v. Reivitz*, 733 F.2d 1226, 1228 (7th Cir. 1984).

Congress chose to "give[] the States flexibility and discretion * * * to formulate their own methods and standards of payment" (S. Rep. No 471, *supra*, at 28-29).¹⁴ By the same token, Congress intended that the degree of federal oversight should be significantly reduced. While pointing out that the Secretary would continue to insist on "assurances * * * that the payment rates * * * are reasonable and adequate," Congress "expect[ed] that the Secretary will keep regulatory and other requirements to that minimum necessary to assure proper accountability, and not to overburden the States and facilities with marginal but massive paperwork requirements" (*id.* at 29).

In enacting the Boren Amendment, therefore, Congress made clear that it did not envision rigorous federal scrutiny of the States' "assurances" under Section 1396a(a)(13)(A). To the contrary, Congress "expected that the assurances made by the States will be considered satisfactory in the absence of a formal finding to the contrary by the Secretary." S. Rep. No. 471, *supra*, at 29. See also 126 Cong. Rec. 17886 (1980) (Sen. Boren) ("[P]ayment methods adopted by the States will carry a presumption of compliance"). Indeed, the 1980 Conference Report stated that "[i]f, within 90 days of receiving the rates proposed to be used by a State, the Secretary has not made a final determination that the rates proposed meet all applicable requirements of medicaid law, then the rates would be presumed to meet the medicaid law requirements for the fiscal

¹⁴ There was no Senate or House report accompanying the Boren Amendment in 1980. Floor discussion on the Amendment, however, makes clear that it was drawn from a bill reported the previous year by the Senate Finance Committee. See 126 Cong. Rec. 17885-17886 (1980). The Boren Amendment does not materially differ from the provision contained in the 1979 bill. See S. Rep. No. 471, *supra*, at 157-158. For that reason, we have set out in the text the relevant portions of the Senate report that accompanied the 1979 bill.

year for which they were imposed" (H.R. Conf. Rep. No. 1479, 96th Cong., 2d Sess. 154 (1980)). Consistently with this legislative history, the Secretary has maintained that Section 1396a(a)(13)(A) does not require him to analyze or verify the State's findings, but only to satisfy himself that there is a reasonable basis on which the State's assurances may be accepted. 48 Fed. Reg. 56,051 (1983).

The Boren Amendment, in short, was designed to promote two closely connected purposes. First, in order to reduce the cost of participating in the Medicaid program, the Amendment freed the States of the constraints previously imposed by the "reasonable cost" formula, and allowed state agencies "to establish rates on a statewide or other geographical basis, a class basis, or an institution-by-institution basis" (S. Rep. No. 471, *supra*, at 29). Second, the Amendment was intended to reduce the degree of federal oversight, on the theory that excessive federal scrutiny had "overburden[ed] the States and facilities with marginal but massive paperwork requirements" (*ibid.*).¹⁵ In light of these purposes—carefully reflected in the plain language of

¹⁵ In promulgating the regulations that implement Section 1396a(a)(13)(A), the Secretary reiterated in a preamble that the federal government should avoid excessive interference with the States' rate-setting authority under the Medicaid program. For example, several commenters had proposed during the notice and comment period that the Secretary "be more explicit as to [the federal] criteria for review of State assurances" (48 Fed. Reg. 56,050 (1983)). The Secretary rejected that suggestion (*ibid.*), finding that "such a list of criteria may be viewed as imposing Federal standards for repayment rates, an effect that would be contrary to the legislative intent." For the same reason, the Secretary rejected a proposal that the federal government define the term "efficiently and economically operated Facility" as used in Section 1396a(a)(13)(A). See 48 Fed. Reg. 56,049 (1983). As the Secretary put it (*ibid.*), "we believe any Federal attempt to impose specific definitions would unnecessarily intrude upon the legislatively mandated flexibility provided to States under the statute."

Section 1396a(a)(13)(A)—it is difficult to imagine that Congress intended to authorize federal courts, in actions brought against the States under Section 1983, to develop and apply a federal common law respecting the “reasonableness” of particular Medicaid reimbursement rates.

b. The court of appeals took a different view of the legislative history of Section 1396a(a)(13)(A), but its conclusions cannot withstand analysis. Examining, first, the Joint Explanatory Statement of the Committee of Conference, the court observed that the Committee had stated “flatly” that it “intend[ed] that state hospital reimbursement policies should meet the costs that must be incurred by efficiently administered hospitals in providing covered care and services to medicaid eligibles’ ” (Pet. App. A8). The court, however, misconstrues those remarks. Read in context, the Conference Committee report simply explained that Congress had decided to jettison the “reasonable cost” reimbursement formula for hospitals, in favor of the more flexible standard previously adopted in the Boren Amendment for skilled nursing and intermediate care facilities. To accomplish that purpose, the 1981 legislation added hospitals to the list of facilities already covered by Section 1396a(a)(13)(A)—a provision which included the language at issue in this case: “which the State finds, and makes assurances satisfactory to the Secretary.” There is no suggestion in the legislative history that Congress intended to confer on private parties an enforceable right to a “reasonable and adequate” rate schedule.

The court of appeals recognized that “[t]he legislative history *** indicates that Congress intended no close scrutiny by the Secretary of Virginia’s assurances of compliance with the mandates of § 1396a(a)(13)(A).” Pet. App. A9. And it acknowledged that one “logical reading” of that history is that Congress sought to “insulate[] State reimbursement programs from challenges by hospitals com-

pensated at new, lower rates.” *Ibid.* The court, however, drew the opposite conclusion: it surmised that Congress intended to “guarantee[] reasonable and adequate reimbursement to hospitals that achieve cost-efficiency.” *Ibid.*

We believe that the “logical reading” offers a better account of the evidence: Congress did not intend to confer on Medicaid providers an “enforceable right” to challenge state reimbursement decisions in federal court. Lawsuits like respondent’s interfere with state autonomy and discretion, and they contravene Congress’s intent that the degree of federal oversight be minimized. There is no reason to believe that Congress wished the participating States to absorb the substantial costs entailed by such litigation.¹⁶

¹⁶ Four years prior to the Boren Amendment, Congress had amended the Social Security Act to repeal 42 U.S.C. 1396a(g) (Supp. V 1975), a provision that had required participating States to waive their Eleventh Amendment immunity from suits brought with respect to Medicaid payment for inpatient hospital services. Act of Oct. 18, 1976, Pub. L. No. 94-552, 90 Stat. 2540; see H.R. Rep. No. 1122, 94th Cong., 2d Sess. 1 (1976); S. Rep. 94-1240, 94th Cong., 2d Sess. 1 (1976). Congress repealed that provision, which had been enacted just the previous year, because it had “require[d] States to waive one of their basic rights” and had resulted in “an unreasonable burden of suits which [had been] costly in terms of time and legal manpower, and which [had made] efficient program administration virtually impossible” (H.R. Rep. No. 1122, *supra*, at 4). The House and Senate reports observed in passing that, after the repeal, “providers can continue * * * to institute suit for injunctive relief in State or Federal courts, as necessary.” *Id.* at 7 (letter from Department of HEW); S. Rep. No. 1240, *supra*, at 4. Those remarks, however, cannot determine the availability of a Section 1983 cause of action under Section 1396a(a)(13)(A) as it now exists. As noted above (pages 18-22 & note 13, *supra*), Congress substantially revised that Section in 1980 and 1981 for the express purpose of conferring greater discretion upon the individual States in structuring their reimbursement systems, while at the same time reducing significantly the degree of federal oversight. Whatever federal remedies may have been available to Medicaid providers under the old “reasonable cost”

CONCLUSION

The judgment of the court of appeals should be reversed.
Respectfully submitted.

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reimbursement system, therefore, did not survive Congress's substantial revision of Section 1396a(a)(13)(A) in 1980.

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

GERALD L. BALILES, *et al.*,
Petitioners,
v.

THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

On Writ of Certiorari to the United States
Court of Appeals for the Fourth Circuit

BRIEF OF THE
NATIONAL GOVERNORS' ASSOCIATION,
NATIONAL ASSOCIATION OF COUNTIES,
COUNCIL OF STATE GOVERNMENTS,
U.S. CONFERENCE OF MAYORS,
INTERNATIONAL CITY MANAGEMENT ASSOCIATION,
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AND NATIONAL LEAGUE OF CITIES
AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Whether the Medicaid statute confers on health care providers a substantive federal right enforceable through 42 U.S.C. § 1983 to challenge a State's reimbursement plan in federal court.

(i)

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

No. 88-2043

GERALD L. BALILES, *et al.*,
Petitioners,
v.

THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

**On Writ of Certiorari to the United States
Court of Appeals for the Fourth Circuit**

BRIEF OF THE
NATIONAL GOVERNORS' ASSOCIATION,
NATIONAL ASSOCIATION OF COUNTIES,
COUNCIL OF STATE GOVERNMENTS,
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NATIONAL CONFERENCE OF STATE LEGISLATURES,
AND NATIONAL LEAGUE OF CITIES
AS AMICI CURIAE IN SUPPORT OF PETITIONERS

INTEREST OF THE AMICI CURIAE

The *amici* are organizations whose members include state, county, and municipal governments and officials throughout the United States. *Amici* and their members have a compelling interest in legal issues that affect state and local governments.

This case is of importance to *amici* because it is another example of the proliferation of actions filed under 42 U.S.C. § 1983 against States and their political subdivisions to vindicate alleged federal rights arising from

federal grant programs. Such litigation disrupts the federal-state relationship under these programs and undermines the States' functions and prerogatives.

This case attacks Virginia's plan for administering its Medicaid program. Medicaid, a cooperative federal-state program that provides funds for medical services for the needy, leaves to each State the determination of eligibility requirements and reimbursement rates for patients and health care providers. The federal law and regulations evidence two concerns: to provide adequate health care to Medicaid recipients and to contain costs.

State plans are subject to review and approval by the United States Department of Health and Human Services ("HHS"). Virginia's plan has been approved. Nonetheless, respondent asserts that Virginia's plan violates its members' rights under the federal Constitution, laws, and regulations. Respondent's specific claim is that Virginia's plan yields reimbursement rates that do not conform to the requirements of the Medicaid Act in that they do not reasonably and adequately meet the costs of efficiently operated hospitals. But respondent can point to no specific violations of the detailed federal law and regulations or of the Constitution.

Federal law requires each State to administer its plan through a special state agency and to establish administrative hearing processes to resolve disputes. The ruling below permits respondent to bypass those procedures in order to assert in federal court purported rights that exist only by virtue of state law. The decision permits, indeed requires, a federal court to define, in the first instance, a right that is a creature of state law. Moreover, it turns every dispute arising out of the State's administration of a federal-state cooperative program into a federal case. It exposes States and their political subdivisions to heavy potential financial liability, which Congress itself chose not to impose. Finally, it denigrates the state administrative procedures mandated by Congress

by making the federal courts the initial claims agency for all dissatisfied Medicaid health care recipients and providers. Thus, the decision below, in both its substantive and procedural aspects, poses a threat to the independence and integrity of the sovereign States in our federal system.

Amici submit that the decision below is wrong. Because this Court's decision will have a direct effect on matters of prime importance to *amici* and their members, *amici* submit this brief to assist the Court in its resolution of the case.¹

STATEMENT

Respondent Virginia Hospital Association ("VHA") is a nonprofit organization whose members are public or private Virginia health care providers. A portion of each member's revenues is derived from its participation in the Medicaid Assistance Program, 42 U.S.C. § 1396 *et seq.* ("Medicaid program"), administered by petitioner Commonwealth of Virginia, Department of Medical Assistance Services ("DMAS").² VHA believes that its members are entitled to more money from DMAS.

Virginia, like every State, has citizens who cannot afford adequate health care. In order to assist these needy persons, Virginia chooses to participate in the Medicaid program, a federal-state partnership designed to provide health care services to the poor. See *Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985). Under Medicaid, the federal government provides the bulk of the funding of medical care for the needy, while the States actually develop, administer, and implement the program in accordance with their own state Medicaid plans, which must be approved by the Secretary of HHS. *Ibid.* If

¹ The parties' letters of consent, pursuant to Rule 36 of the Rules of this Court, have been filed with the Clerk of the Court.

² Petitioners are officials of the Commonwealth of Virginia: Gerald Baliles, the Governor; Eva S. Teig, Secretary of Human Resources; and twelve members of the Board of DMAS.

the terms or administration of the state plan do not conform to federal standards, the Secretary of HHS is authorized to withhold all or part of the federal funding. 42 U.S.C. § 1396c. The Medicaid statute requires participating States to "provide for procedures of prepayment and postpayment claims review." 42 U.S.C. § 1396a(a) (37) (B).

Virginia's Medicaid plan ("Virginia plan") has both a substantive and a procedural component. The substantive component consists of the methodology whereby DMAS sets prospective *per diem* rates for inpatient care of Medicaid patients (the "reimbursement system"). In brief, the reimbursement system establishes seven categories of hospitals ("peer groups") based on geographical location (urban/rural) and size (number of beds per hospital). For each peer group, a baseline for reimbursement rates is calculated using cost medians per patient day derived from 1981 hospital cost reports. Further rate adjustments are made for urban peer groups to allow for wage variations between metropolitan areas. Wage differentials are based upon labor costs in the Standard Metropolitan Statistical Areas as developed by the federal Office of Management and Budget. Once each peer group's median cost per day is thus established, that amount functions as a quarterly ceiling on reimbursement rates within that peer group, as increased periodically through the use of an inflation index. Effective July 1, 1982, the reimbursement system was approved by the Health Care Financing Administration ("HFCA"), the agency of HHS with the responsibility to ensure the compliance of state reimbursement systems with the Medicaid Act and its implementing regulations. In *Mary Washington Hospital v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985), an action brought by a member hospital of VHA, the district court upheld the legality of the reimbursement system in its entirety.²

² Subsequent changes made to the reimbursement system are not relevant to this litigation. They include, for example, changes in audit procedures and scope of Medicaid coverage.

The procedural component of Virginia's plan consists of regulations prescribing procedures for the filing and processing of appeals by health care providers not satisfied with their prospective rates (the "appeals system"). Under the appeals system, rate reimbursement disputes are resolved by a three-level administrative review process (informal conference, formal hearing, and agency head decision). Va. Code Ann. 9-6.14:11 *et seq.* (1989). At each stage, administrators are guided by comprehensive regulations. A provider is entitled at each stage to introduce a wide variety of evidence demonstrating that it operates under unique conditions not shared by other members of its peer group and that it is economically and efficiently operated. See generally *State Plan Under Title XIX of the Social Security Act*, Exhibit 1 of Respondent's Amended Complaint, J.A. 24-45. A provider dissatisfied with the administrative decision may appeal to the Virginia circuit courts and to the Virginia Court of Appeals. Thereafter, appeal to the Virginia Supreme Court is available by writ. Va. Code Ann. § 9-6.14:16 *et seq.* (1989). This appeals system was approved by the HCFA in March 1986 and was upheld by the local federal district court.

Respondent, failing to avail itself of this congressionally mandated (42 U.S.C. § 1396a(a) (37) (B)) appeals process, filed this federal court suit under, *inter alia*, 42 U.S.C. § 1983, seeking declaratory and injunctive relief. Respondent alleged, *inter alia*, that the reimbursement rates established under Virginia's reimbursement system do not conform to the requirements of the Medicaid Act in that they do not reasonably and adequately meet the costs of efficiently and economically operated hospitals. Amended Complaint ¶¶ 1, 17, J.A. 3-4, 13. Determining that respondent was in privity with the plaintiff in *Mary Washington Hospital v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985), the district court dismissed the complaint on grounds of collateral estoppel. The Fourth Circuit reversed and remanded. *Virginia Hospital Ass'n v. Baliles*, 830 F.2d 1308 (4th Cir. 1987).

On remand, Virginia moved to dismiss the complaint on eight jurisdictional grounds. The district court denied the motion and certified the eight issues to the Fourth Circuit for interlocutory appeal. The court of appeals affirmed, holding, in part, that the respondent's complaint stated a cause of action under 42 U.S.C. § 1983. Relying on *Maine v. Thiboutot*, 448 U.S. 1 (1980), and *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981) ("Pennhurst I"), the court of appeals held that: (1) the language and legislative history of 42 U.S.C. § 1396a(a) (13) (A) of the Medicaid Act reveal a congressional intent both to allow providers a private right of action against States for their failure to comply with the Medicaid Act⁴ and to ensure providers reimbursement rates that are reasonable and adequate in fact, and (2) the enforcement mechanisms, including congressionally mandated state administrative appeals and remedies, are not so elaborate as to reveal a congressional intent to foreclose private judicial redress against a State through a Section 1983 proceeding. Pet. App. A-5 to A-12.

SUMMARY OF ARGUMENT

Title 42 U.S.C. § 1983 provides a remedy for the deprivation of a right, privilege, or immunity secured by the Constitution or by federal law, and only when Congress has not indicated an intent to foreclose such a remedy.

Medicaid is a federal-state cooperative endeavor to provide medical services for the needy. Federal law estab-

⁴ The court appears to have been confused about what issue it was deciding. At one point it framed the issue as "whether the Medicaid Act provides VHA with any substantive right." Pet. App. A-5. Elsewhere the court framed the issue as "analyzing a claim of an implied right of action." *Id.* at A-10 n.7. These are two distinct issues. The threshold inquiry is whether the statute confers a substantive right. If it does, then the issue is whether there is a private cause of action under the statute or Section 1983 to enforce that right. See *Pennhurst I*, 451 U.S. at 28 n.21 (citing *Southeastern Community College v. Davis*, 442 U.S. 397, 404 n.5 (1979)).

lishes no entitlement to any particular level of patient care reimbursement. It permits each participating State to develop its own plan and reimbursement rates. Amendments to the original Medicaid Act have granted the States progressively wider discretion in determining and applying their rate-setting methodology.

Respondent's assertion of a federal right to "reasonable and adequate" reimbursement under the Medicaid statute finds no support in the language, legislative history, or relevant agency interpretation of this law. The statute does not explicitly confer nor does it imply such a right. The statute requires only that a state plan provide for reimbursement that is reasonable and adequate as determined by the methods and standards adopted by each State and approved by the Secretary of HHS. By focusing on the state plans, the statute establishes a structure of federal-state relations rather than conferring individual rights.

The decision below rested primarily on the grounds that the purpose of the Medicaid Act is to provide reasonable and adequate reimbursement rates and that respondent was among the intended beneficiaries of the program. But the Medicaid Act does not contain the type of language from which rights can be inferred. Further, decisions of this Court have made clear that an intended benefit is not sufficient to create an enforceable right. Finally, providers like members of VHA are not the holders of any "right" that the Medicaid Act might confer.

Even if respondent has a right to "reasonable and adequate" reimbursement, state law so thoroughly gives meaning and effect to this general standard that this right cannot reasonably be said to be a federal right secured by federal law. State law rights or rights secured by state law are not enforceable under Section 1983.

In any event, whatever right respondent may derive from the Medicaid law, the comprehensive remedies mandated by that statute indicate that Congress intended to

foreclose its enforcement under Section 1983. Primary among these remedies are the congressionally mandated state appeals systems. Virginia's appeals procedures are designed to, and in practice do, secure whatever rights are granted by its reimbursement system. Federal oversight mechanisms compliment Virginia's appeals system in securing these rights. These remedies are sufficient to secure whatever rights are granted by the Medicaid program and Virginia's voluntary participation in it. Moreover, allowing respondent to engraft a Section 1983 remedy onto the Medicaid Act would seriously impair the effectiveness of Virginia's reimbursement and appeals systems.

Respondent's argument that the "reasonable and adequate" reimbursement standard in the Medicaid statute is independent of Virginia's plan would, if successful, require this Court to rewrite the Medicaid statute and thereby nullify the carefully crafted scheme for state administration of the Medicaid program in accordance with state plans. This course would have profoundly adverse consequences for federal-state relations and would swamp the federal courts with similar suits.

ARGUMENT

THE MEDICAID STATUTE GIVES RESPONDENT NO SUBSTANTIVE FEDERAL RIGHT TO REASONABLE AND ADEQUATE REIMBURSEMENT ENFORCEABLE UNDER 42 U.S.C. § 1983.

A cognizable claim under 42 U.S.C. § 1983 has three distinct predicates. The claim must (1) arise out of the deprivation of an enforceable right (see *Pennhurst I*, 451 U.S. at 22 & n.16), (2) that is secured by federal law (see *Martinez v. California*, 444 U.S. 277, 285 (1980)), (3) for which Congress has not provided a comprehensive remedy (see *Middlesex County Sewerage Authority v. National Sea Clammers Ass'n*, 453 U.S. 1, 20-21 (1981) ("Sea Clammers")). Because respondent has not satisfied even one of these requirements, its action is not cognizable under Section 1983.

A. Respondent's Allegations Do Not Establish A Violation Of A Federal Right Enforceable Under Section 1983.

Respondent alleges that the *per diem* reimbursement rates established by the methods and standards of Virginia's Medicaid plan violate the Medicaid Act and regulations in that they "have not reasonably nor adequately met the costs incurred by economically and efficiently operated hospitals." Amended Complaint ¶ 17, J.A. 13; see also ¶¶ 1, 35, 39, J.A. 3-4, 20, 21. By grounding its cause of action in 42 U.S.C. § 1983,⁵ respondent apparently believes that DMAS' refusal to pay VHA members at a higher rate constitutes a violation of a right secured to the VHA by federal law. But nowhere does respondent identify any right that has been violated or how DMAS' refusal to pay VHA members at a higher rate constitutes a violation of this unidentified right. Respondent apparently seeks to assert a right to "reasonable and adequate" reimbursement under 42 U.S.C. § 1396a (a) (13) (A), commonly known as the Boren Amendment to the Medicaid Act. But this purported right does not have a basis in the plain language of the statute itself, its legislative history (particularly the trend toward state discretion), or the interpretation of the relevant federal agency. Respondent's interest in "reasonable and adequate" reimbursement does not rise to the level of an enforceable federal right.

The Boren Amendment provides that:

[a] State plan for medical assistance must . . . provide . . . for payment . . . of . . . services provided under the plan through the use of rates (determined in accordance with methods and standards developed by the State . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be

⁵ See Amended Complaint, ¶¶ 2, 35, 37, 39, J.A. 4, 20, 21.

incurred by efficiently and economically operated facilities

42 U.S.C. § 1396a(a)(13)(A) (emphasis added). This language does not itself expressly confer on providers a right to reasonable and adequate reimbursement. This congressional silence is significant. Had Congress intended to create such a right, it surely knew how to do so. See *Pennhurst I*, 451 U.S. at 17-18, 27, citing *King v. Smith*, 392 U.S. 309, 333 (1968), and *Southeastern Community College v. Davis*, 442 U.S. 397, 411 (1979). See also *Rose v. Rose*, 481 U.S. 619, 628 (1987). The usual way for Congress to confer such a right is through the explicit use in the statute of "right- or duty-creating language" that benefits a specific class of persons. *Cannon v. University of Chicago*, 441 U.S. 677, 690 n.13 (1979). There is no such language in the Amendment or anywhere else in the Medicaid Act. In fact, the Amendment speaks only of a state Medicaid plan, and not of actual reimbursement rates for providers. The Amendment does not require any specific plan, but only that the State, if it wishes to participate in Medicaid have a plan that is approved by the Secretary of HHS. The focus is on the state system and not on providers.⁶ Cf. *Pennhurst I*, 451 U.S. at 22 (rather than conferring individual rights, Developmentally Disabled Assistance and Bill of Rights Act has "systemic focus"). The fact that Congress chose not to use explicit language of rights and duties in the Boren Amendment strongly suggests that it did not intend to create such rights and duties through this Amendment.

The court of appeals recognized that the Boren Amendment does not expressly confer any rights on providers (Pet. App. A-5), but found in the Amendment an im-

⁶ Moreover, as this Court made clear in *Pennhurst I*, even the use of explicit language of rights and duties is not dispositive as to Congress's intent to confer rights. Congress's use of such explicit language may simply be its way of "encouraging a specific type of treatment" rather than "mandating it." *Pennhurst I*, 451 U.S. at 27.

plied substantive right on behalf of health care providers to reasonable and adequate reimbursement rates. Its analysis began with its view that the "express purpose" of this statute "is to require reimbursement rates that are 'reasonable and adequate to meet the costs . . . incurred by efficiently and economically operated [providers] . . . and to assure that [Medicaid patients] have reasonable access . . . to inpatient hospital services of adequate quality.'" Pet. App. A-7, citing 42 U.S.C. § 1396a(a)(13)(A) (ellipses and brackets in original). This interpretation exhibits a fundamental misunderstanding of the structure of federal-state relations established by the Medicaid Act in general and the Boren Amendment in particular.

Medicaid is a federal-state "cooperative endeavor." *Harris v. McRae*, 448 U.S. 297, 308 (1980). The federal government approves plans submitted by each State for funding medical services to the poor and subsidizes a significant portion of the costs incurred by the States, but each State administers the program in conformity with its own plan. See *Alexander v. Choate*, 469 U.S. at 289 n.1.

Originally, the States had no choice in administering Medicare but to reimburse health care facilities according to the cost methodology used by the federal government. But in 1972, concerned about escalating costs, Congress adopted the "reasonable cost related standard" for reimbursement, thereby allowing States to make their own reimbursement decisions and giving them flexibility in achieving satisfactory payment arrangements with health care facilities. H.R. Rep. No. 231, 92d Cong., 1st Sess. 101 (1971).⁷ In 1980, Congress was again concerned

⁷ As the court observed in *Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388, 392 (5th Cir. 1980):

Congress intended that state authorities in developing methodologies for reasonable cost related reimbursement have great flexibility in the areas of cost-finding and rate-setting. The legislative history indicates that states are to be free to experiment with methods and standards for payment that

about the inflationary effect of the Medicaid reimbursement standard. Accordingly, by the Boren Amendment, Congress instituted the current reimbursement standard, which requires reasonable and adequate rates as determined by methods and standards developed by the State.

Through the Boren Amendment Congress expanded, yet again, the States' discretion in developing and implementing reimbursement methodologies.⁸ Its plain language expresses Congress's clear intent that reimbursement rates are to be determined in accordance with state, not federal, methods and standards. The executive branch, through HCFA,⁹ has acknowledged the "legislatively mandated flexibility" that the statute grants to the States in determining reimbursement rates. 48 Fed. Reg. 56049 (1983). Accordingly, HCFA has specifically declined to issue more "explicit criteria for Federal review of States' methods and standards for establishing payment rates" lest "such a list of criteria . . . be viewed as imposing Federal standards for payment rates, an effect that would

would be simpler and less expensive than the complex Medicare reasonable cost formula. See S. Rep. No. 92-1230, 92d Cong., 2d Sess. 287 (1972). . . . Additionally, Congress intended that states have freedom both to define allowable cost items and to set a value on the reasonable cost of such items.

⁸ The legislative history behind the 1981 amendment extending the Boren Amendment to hospitals as well as other long-term care facilities indicates that

[i]n eliminating the current requirement that States pay hospitals on a Medicare "reasonable cost" basis for inpatient services under Medicaid, the Committee recognizes the inflationary nature of the current cost reimbursement system and intends to give States greater latitude in developing and implementing alternative reimbursement methodologies that promote the efficient and economical delivery of such services. H.R. Rep. No. 158, 97th Cong., 1st Sess. 293 (1981).

⁹ HCFA, an agency of HHS, must approve reimbursement rates set by state Medicaid plans. Its opinion is entitled to deference. *Wright v. Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418, 430 (1987); *Schweiker v. Hogan*, 457 U.S. 569, 588 (1982); *Blum v. Bacon*, 457 U.S. 132, 141 (1982).

be contrary to the legislative intent." 48 Fed. Reg. 56050 (1983). In short, Congress's purpose in enacting the 1972 "reasonable cost related standard" and the Boren Amendment was to control costs by departing from a federal reimbursement standard and allowing the States to adopt their own standards.

Once the court of appeals improperly inferred the "express" purpose of the Boren Amendment, it concluded that the Amendment "reveals an unambiguous intent to assure reimbursement rates that are reasonable and adequate in fact." Pet. App. A-7. Assuming, *arguendo*, that this conclusion is correct,¹⁰ it still does not follow that the Boren Amendment creates a substantive right to such a level of reimbursement.

This crucial and dispositive point merits extended discussion. This Court has held that federal statutes imply substantive rights that can be enforced through Section 1983 when the statute contains unambiguous and specific language that effectively imposes binding obligations on the States. *Pennhurst I*, 451 U.S. at 17, 24-27. Federal statutes imply substantive rights through "specific language of obligation [that] narrowly cabins the discretion of officials" (*Edwards v. District of Columbia*, 821 F.2d 651, 656 (D.C. Cir. 1987)), or through "language [that]

¹⁰ There is good reason to believe that this conclusion is wrong. Most important, it assumes that there is an objective standard ("in fact") by which to judge what rates are reasonable and adequate. But "reasonableness" and "adequacy" are relative to what other providers are spending. Congress found that when it operated on the assumption of objectively reasonable rates prior to the enactment of the Boren Amendment, its cost reimbursement system was inherently inflationary. See nn. 7 & 8, *supra*. That is, the prior "reasonable" cost standard gave providers collectively an incentive to spend more so as to raise the rate of "reasonable" reimbursement. Respondent is asking this Court to read out of the Boren Amendment the mechanism that Congress explicitly adopted to minimize this inflationary effect, namely, the state plans. In our view, this request should be directed to Congress, not to the courts.

is unequivocally specific and mandatory." *Samuels v. District of Columbia*, 770 F.2d 184, 197 (D.C. Cir. 1985). See also *Alexander v. Choate*, 469 U.S. at 307-08 n.32. The Medicaid Act contains no specific obligation-imposing language that would give substance to the "right" to "reasonable and adequate" reimbursement. Thus there is no basis for inferring such a right from the Medicaid Act or its implementing regulations. See, e.g., 42 C.F.R. §§ 447.250-447.253 (1988) (repeating the general language of the Boren Amendment).¹¹ Especially significant in this regard is the Act's express statement of its purpose as that "of enabling each State, as far as practicable under the conditions in such State, to furnish . . . medical assistance on behalf of families . . . or disabled individuals . . . and . . . to help such families and individuals." 42 U.S.C. § 1396; see also *Schweiker v. Hogan*, 457 U.S. 569, 571 (1982). This is not the sort of language from which substantive rights can be inferred. Congress framed the statute in terms of "enabling" the States to aid the needy, rather than "obligating" them to do so.

This statement of purpose also serves to make clear that Congress intended the Medicaid program to benefit certain individuals. But simply because Congress intends to benefit a class of persons through a statute does not mean it intends to create for them a right to the benefit conferred. See *Bowen v. Gilliard*, 483 U.S. 587, 604-09 (1987); *Heckler v. Turner*, 470 U.S. 184, 189-90 & n.3 (1985).

¹¹ The generality and vagueness of the "reasonable and adequate" standard of the Boren Amendment and its implementing regulations distinguish the present case from *Wright v. Roanoke Redevelopment*. In *Wright*, the Court found that the Brooke Amendment "could not be clearer" in imposing a specific "mandatory limitation" on rent charges. 479 U.S. at 430. On the basis of this specific language the Court concluded that "[t]he intent to benefit tenants is undeniable." *Ibid.* No such specific language is to be found in the present case, and hence there is no basis from which to infer an intent to confer rights on providers.

Pennhurst I illustrates this distinction. *Pennhurst I* dealt with the Developmentally Disabled Assistance and Bill of Rights Act, 42 U.S.C. § 6000 *et seq.*, which the Court recognized was intended to benefit the developmentally disabled. See *Pennhurst I*, 451 U.S. at 11. Yet the Court, with specific reference to Medicaid, the very statute involved in this case, stated:

In sum, nothing suggests that Congress intended the Act to be something other than a typical funding statute. Far from requiring the States to fund newly declared individual rights, the Act has a systematic focus, seeking to improve care to individuals by encouraging better state planning, coordination, and demonstration projects. Much like the Medicaid statute . . . the Act at issue here "was designed as a cooperative program of shared responsibilit[ies], not as a device for the Federal Government to compel a State to provide services that Congress itself is unwilling to fund."

Id. at 22 (quoting *Harris v. McRae*, 448 U.S. at 309).

Similarly, in *Alexander v. Choate*, the Court rejected the contention by a class of handicapped persons that Tennessee's Medicaid plan, which imposed a limit of fourteen days of inpatient hospital care per year, constituted discrimination under Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. Writing for a unanimous Court, Justice Marshall explained (469 U.S. at 302-03):

Medicaid programs do not guarantee that each recipient will receive that level of health care precisely tailored to his or her particular needs. Instead, the benefit provided through Medicaid is a particular package of health care services, such as 14 days of inpatient coverage. That package of services has the general aim of assuring that individuals will receive necessary medical care, but the benefit provided remains the individual services offered—not "adequate health care."

The federal Medicaid Act makes this point clear. The Act gives the States substantial discretion to choose the proper mix of amount, scope, and duration limitations on coverage, as long as care and services are provided in "the best interests of the recipients." 42 U.S.C. § 1396a(a)(19).

Moreover, even if the Medicaid Act could be construed to create a substantive right, the holders of this right are not health care providers like the members of the VHA, but rather are Medicaid recipients, i.e., patients of the VHA's members. The purpose of the Act is "to furnish . . . medical assistance on behalf of families . . . or disabled individuals . . . and . . . to help such families and individuals." 42 U.S.C. § 1396. This statutory language is conspicuous in its failure to mention the interests of providers at all. Medicaid was created to aid participating States in "the funding of medical services for the needy" (*Alexander v. Choate*, 469 U.S. at 289 n.1), not for providers.¹²

In sum, there is no support in any of the sources of statutory interpretation for respondent's claim that the Boren Amendment establishes reasonable and adequate rates *simpliciter* as the Medicaid reimbursement standard. Rather, the plain language of the Amendment provides that the standard for reimbursement is rates that the State finds are reasonable and adequate according to methods and standards developed by the State and ac-

¹² As the Second Circuit has observed: "That a particular nursing facility cannot survive without Medicaid participation was certainly not Congress' foremost consideration in its creation of the Medicaid program. . . . The benefits to a nursing home from its participation in Medicaid reimbursement results from nothing more than a statutory business relationship." *Case v. Weinberger*, 523 F.2d 602, 607 (2d Cir. 1975) (footnote omitted). See *Schweiker v. Hogan*, 457 U.S. 569 (1982) (health care recipient may bring an action under the Medicaid Act); *Geriatrics, Inc. v. Harris*, 640 F.2d 262, 265 (10th Cir.), cert. denied, 454 U.S. 832 (1981); *Green v. Cashman*, 605 F.2d 945, 946 (6th Cir. 1979); see also *Silver v. Baggiano*, 804 F.2d 1211, 1216 n.3 (11th Cir. 1986).

cepted by the Secretary. See also 42 C.F.R. § 447.253 (1988) (state Medicaid agencies are only required to "make . . . findings" that their rates are "reasonable and adequate"). If this standard gives content to a right, it is no more than the right to an approved state plan providing for methods and standards by which the State determines what rates are reasonable and adequate reimbursement to health care providers generally. Moreover, assuming that a State chooses to participate in the Medicaid program, this "right" is violated only if either (1) the State does not have a plan, (2) the rates set are not in accord with the methods and standards in the plan, or (3) the methods and standards in the plan have not been accepted by the Secretary. None of these circumstances exists in the present case, and respondent does not allege that any does.

B. Assuming *Arguendo* That Respondent Has A Substantive Right To Reasonable And Adequate Rates Under the Medicaid Act, It Is Not A Right Secured By Federal Law.

Section 1983 affords relief only to a plaintiff deprived of a right, privilege, or immunity secured by the Constitution or federal law. See *Martinez v. California*, 444 U.S. at 285. That predicate is lacking in this case.

Even assuming that respondent has a right to "reasonable and adequate" reimbursement under the Boren Amendment, it is not a federal right in any meaningful sense. The state plans so thoroughly give meaning and effect to this "amorphous objective"¹³ of "reasonable and adequate" reimbursement rates that the "right" to such a rate is a federal right only in the most formalistic sense, namely, that these words appear in a federal statute. Rather, the Medicaid Act, specifically, the Boren Amendment, and its regulations are designed so that the States are to provide whatever specific obligation-imposing and

¹³ *Alexander v. Choate*, 469 U.S. at 303 (using this phrase to describe "adequate health care").

discretion-limiting language they think appropriate (subject to the Secretary's approval) in their state plans. If there are specific substantive rights and duties as to reimbursement rates, they are created by the state plans. If such rights exist, then, they are state rights, not federal rights. See *Oberlander v. Perales*, 740 F.2d 116, 119 (2d Cir. 1984) ("there is no authority anywhere supporting the proposition that a state Medicaid regulation becomes a federal law merely by virtue of its inclusion in a state plan required by federal law"). As we discuss below, consistent with their status as state rights, the primary mechanisms for enforcing these rights are the state appeals systems. Thus these rights are not only state rights, but they are "secured by" state law, not federal law. And violations of state rights or rights "secured by" state law do not of themselves give rise to Section 1983 actions. See *Paul v. Davis*, 424 U.S. 693, 694, 699-702 (1976).

C. The Federal And State Remedies Provided For By The Medicaid Statute Are Sufficiently Comprehensive to Foreclose Private Actions Under Section 1983.

This Court has held that "[w]hen the remedial devices provided in a particular Act are sufficiently comprehensive, they may suffice to demonstrate congressional intent to preclude the remedy of suits under § 1983." *Sea Clammers*, 453 U.S. at 20. The general rule to be derived from this Court's applications of the *Sea Clammers* test is that a remedial scheme is sufficiently comprehensive if it contains all of those remedial procedures that are jointly necessary and sufficient to secure the substantive rights conferred by the statute.¹⁴ As a corollary to this rule, if the Section 1983 remedy impairs the effectiveness of

¹⁴ See Note, *Comprehensive Remedies and Statutory Section 1983 Actions: Context as a Guide to Procedural Fairness*, 67 Tex. L. Rev. 627, 636 (1989) ("The Court's decisions indicate . . . that a section 1983 remedy is permissible only when the substantive statute fails to provide procedural remedies necessary to accomplish the underlying congressional purposes [of the statute].")

the Medicaid Act's reimbursement or appeals systems in securing the substantive rights conferred by the Act, then Section 1983 ought not to be used to enforce these substantive rights. See *Wright v. Roanoke Redevelopment & Housing Authority*, 479 U.S. 418, 423 (1987) (reading *Smith v. Robinson*, 468 U.S. 992, 1012 (1984), to hold that allowing a plaintiff to circumvent the Education of the Handicapped Act's administrative remedies would be inconsistent with Congress's carefully tailored scheme, which itself allowed private parties to seek remedies for violating federal law); see also *Great American Federal Savings & Loan Ass'n v. Novotny*, 442 U.S. 366, 378 (1979) ("Unimpaired effectiveness can be given to the plan put together by Congress in Title VII only by holding that deprivation of a right created by Title VII cannot be the basis for a cause of action under § 1985(3).").

The analysis must begin by defining the "right" to be protected by the remedies under examination. As we demonstrated in Part B, *supra*, any right to reasonable and adequate reimbursement rates conferred by the Boren Amendment is a state right, not a federal right. The remedial devices that Congress has mandated under the Medicaid Act reinforce this proposition. Consistent with the limited scope of these "rights" and their grounding in state law, the primary remedial devices under the Medicaid Act are the congressionally mandated state appeals systems. Congress intentionally left the enforcement of the state rights created by the state plans to the state appeals systems. In doing so, Congress manifested its intent to foreclose a Section 1983 remedy.

In enacting the Boren Amendment, Congress had two closely related goals: "[first,] to contain the spiraling costs of inpatient hospital services and [second,] to reduce potentially stifling and expensive federal oversight of state methodologies." *West Virginia University Hospitals v. Casey*, 885 F.2d 11, 23 (3d Cir. 1989). Congress implemented these goals by establishing the state

plans as linchpins of the Medicaid program,¹⁵ and directing the Secretary of HHS to "keep regulatory and other requirements to that minimum necessary to assure proper accountability." S. Rep. No. 471, 96th Cong., 1st Sess. 28, 29 (1979). For example, Congress intended that a State's assurances made to the Secretary will be satisfactory unless by a formal finding the Secretary finds to the contrary. *Ibid.*; see also 42 C.F.R. § 447.256(b) (1988).¹⁶ It is difficult to imagine that in reducing the

¹⁵ The central role intended for state Medicaid plans is evidenced by the statute's framework. The detailed requirements found throughout the statute are all phrased in terms of what a state plan must provide. See 42 U.S.C. § 1396 *et seq.*; see also *Alexander v. Choate*, 469 U.S. at 289 n.1.

¹⁶ Although reduced, federal oversight of state Medicaid plans is still significant. Once approved, the plan is subject to continued scrutiny by the Secretary of HHS to ensure that federal requirements are satisfied. *Charleston Memorial Hosp. v. Conrad*, 693 F.2d 324, 327 (4th Cir. 1982). The Department of HHS, through its Audit Agency, conducts audits annually or as appropriate of the state Medicaid agency's operations. 45 C.F.R. § 201.12 (1988). The Social and Rehabilitation Service of HHS is authorized to conduct a review to ensure that the State is complying with federal administrative requirements. 45 C.F.R. § 201.10 (1988). State Medicaid agencies must, under 42 C.F.R. §§ 431.17, 431.18(f) (1988), maintain records and make program policy materials available to providers who wish them. 48 Fed. Reg. 56051 (1983). If the Secretary of HHS determines that the State is improperly implementing its plan or not following a new federal requirement, he may either completely cut off federal funding (42 U.S.C. § 1396c; 45 C.F.R. § 201.6 (1988)) or "in his discretion" limit payments to "categories under or parts of the state plan not affected by such failure." 42 U.S.C. § 1396c. Finally, whenever a state Medicaid agency makes a change in its reimbursement methods and standards, and in any event at least once annually, the agency must make assurances to HCFA that it has found that its reimbursement rates are reasonable and adequate and that these rates ensure that recipients have reasonable access to providers. 42 C.F.R. § 447.253(a)-(e) (1988); 45 C.F.R. § 201.3 (1988). If this oversight was intended to secure any right, it is at best the "right" of providers to an approved state plan that provides for methods and standards by which the State determines what reimbursement rates are reasonable and adequate. See Part A, *supra*.

role of the federal government and in expanding the role of the States in the Medicaid program, Congress intended to allow private litigants to use Section 1983 in the federal courts to expand again the role of the federal government in the program.

Consistent with the key role played by the state plans in the Medicaid program, Congress intended that the primary remedial measures under Medicaid be at the state level. Each State is required by the Medicaid Act and regulations to provide an appeals system in which prepayment and postpayment claims are reviewed. 42 U.S.C. § 1396a(a)(37)(B). A State must provide written assurances that this "essential" element of its reimbursement plan is met. 48 Fed. Reg. 56056 (1983). The review must take the form of "an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review." 42 C.F.R. § 447.253(c) (1988). Thus, state administrative review must be both comprehensive and quick.

Medicaid regulations require only that the state Medicaid agency provide an appeals procedure "with respect to such issues as the [state] agency determines appropriate." 42 C.F.R. § 447.253(c) (1988). This regulation was promulgated pursuant to Congress's directive that HCFA develop alternative rate dispute resolution mechanisms so that providers would not be totally barred by existing law (apparently a reference to the Eleventh Amendment) from disputing reimbursement rates. S. Rep. No. 1240, 94th Cong., 2d Sess., reprinted in 1976 U.S. Code Cong. & Admin. News 5648, 5649-51. Through an executive agency and directly (in 42 U.S.C. § 1396a (a)(37)(B)), Congress left the decision as to the particulars of each State's appeals system to the State. As HCFA recognized, this decision permits each State to tailor its appeals system to its particular reimbursement system so as best to effectuate that system and secure whatever rights (if any) it confers:

[T]he States, not the Federal government, are in the best position to determine the administrative process that would best meet their needs and be most compatible with their reimbursement system. . . . States are free to establish reasonable criteria for appeals to limit the issues on appeal that may be appropriate. . . .

48 Fed. Reg. 56052 (1983).

Virginia has adopted an appeals system that it has found to be compatible with its reimbursement system and that gives providers reasonable and sufficient opportunities to challenge reimbursement decisions. Under this system, which HCFA has found to be fully satisfactory, health care providers and facility patients may contest DMAS reimbursement and benefit decisions through three levels of administrative review (informal conference, formal hearing, and agency head decision). At each level providers, with the assistance of counsel, may present pertinent facts and evidence. Va. Code Ann. § 9-6.14:11 *et seq.* (1989).¹⁷ If dissatisfied with the decision received at the end of the administrative review, providers or patients may obtain judicial review in three levels of state courts under the Virginia Administrative Process Act. Va. Code Ann. § 9-6.14:1 *et seq.* (1989). Thus, administrative and judicial review of both state benefit and reimbursement decisions were available to respondent as a matter of right.

¹⁷ For example, the hospital can present evidence that its costs are generated by factors not shared by other hospitals in its peer group and that it has taken reasonable action to contain its hospital-wide costs. The hospital can challenge the hearing officer's use of operating and financial ratios and related standards of efficiency, subject only to Virginia's flexible administrative rules. Finally, the hospital can attempt to show that adherence to its current reimbursement rate jeopardizes its long-term financial viability and that the population served by the hospital has no reasonable access to other inpatient hospitals. See *State Plan Under Title XIX of the Social Security Act*, Exhibit 1 of Respondent's Amended Complaint, J.A. 36-41.

Despite Congress's requirement that each State establish an appeals system that best serves its particular reimbursement system, and despite Virginia's compliance with that mandate, respondent alleges (¶ 32 of the Amended Complaint, J.A. 18-20), that Virginia's appeals system is not "meaningful" because, *inter alia*, it makes certain issues (*e.g.*, the establishment of peer groups and the inflation index used) non-appealable. Under *Sea Clammers*, 453 U.S. at 20, however, a remedial scheme can be "sufficiently comprehensive" even if it does not allow for plenary review of all conceivable statutory violations or, what may amount to the same thing, even if it does not allow review and remedies that are as extensive as those provided for in Section 1983. In a related context, this Court held in *Great American Federal Savings & Loan Ass'n v. Novotny*, 442 U.S. at 373-76, that remedies under Title VII of the 1964 Civil Rights Act were sufficient to bar the plaintiff's 42 U.S.C. § 1985(3) remedy even though the Title VII remedies were significantly narrower than those of Section 1985(3).¹⁸ In short, the criterion of sufficiency under *Sea Clammers* is not whether the remedial mechanisms of the statute are as broad as they conceivably could be or as broad as those of some other statute (*e.g.*, Section 1983); rather, the test is whether the remedial mechanisms mandated by the statute effectively secure the substantive rights conferred by that statute. Virginia's appeals system in and of itself, and certainly in combination with federal oversight mechanisms, satisfies this test.

The corollary to the "sufficiently comprehensive" test, namely, whether a Section 1983 remedy would impair the effectiveness of the Medicaid Act, also shows Virginia's appeals system to be sufficiently comprehensive. Permitting a Section 1983 action would impair the ef-

¹⁸ See also *Hervey v. City of Little Rock*, 787 F.2d 1223, 1233 (8th Cir. 1986) (applying *Novotny* to find statutory foreclosure of a Section 1983 suit); *Irby v. Sullivan*, 737 F.2d 1418, 1428-29 (5th Cir. 1984) (same).

fectiveness of Virginia's and other States' reimbursement and appeals systems by moving the forum for rate reimbursement challenges from the States, where they belong, to the federal courthouse, where they do not. Medicaid reimbursement decisions, based as they are on extensive technical data, simply are not conducive to efficient review by federal courts.¹⁹ By contrast, administrative appeals procedures tailored to local conditions are designed to make precisely the sort of prompt, highly factual determinations inherent in rate reimbursement review. Thus it is reasonable to conclude that when Congress established vague standards for lawful conduct such as "reasonableness" and "adequacy" and also mandated administrative mechanisms to interpret and apply the standards, Congress intended to foreclose a Section 1983 remedy.²⁰

The right urged by respondents and accepted by the court below must be seen for what it is: a license to contest in federal court under Section 1983 every reimbursement term in a provider contract and every reimburse-

¹⁹ *Maine v. Thiboutot*, 448 U.S. 1 (1980), stands in sharp contrast. In that case, the issue was whether, in computing Aid to Families with Dependent Children benefits (to which a father was entitled for his three children by a previous marriage), allowance should be made for money spent to support his five children by a current marriage. The claim was based on specific provisions of the federal statute and was a purely legal dispute, not requiring the technical, factual expertise demanded by Medicaid rate reimbursement challenges. Moreover, the claimant had pursued the State's administrative remedies and judicial review procedures.

²⁰ See Sunstein, *Section 1983 and the Private Enforcement of Federal Law*, 49 U. Chi. L. Rev. 394, 414, 428-29 (1982); see also *Local 1325, Retail Clerks Int'l Ass'n v. NLRB*, 414 F.2d 1194, 1199-1200 (D.C. Cir. 1969) (vagueness of statutory standard indicates that Congress intended to give NLRB responsibility to define what collective bargaining units are "appropriate"); cf. *National Railroad Passenger Corp. v. National Ass'n of Railroad Passengers*, 414 U.S. 453, 461-64 (1974) (private suits for injunctions against discontinuance of passenger rail service would undermine orally administrative procedures prescribed by Amtrak Act).

ment rate decision made by a state Medicaid agency. If this license is granted, the sure guidance furnished to States, recipients, and providers by written state reimbursement plans will give way to the vagaries of case-by-case adjudication. The federal courts will become glorified Medicaid claims adjusters, reviewing countless highly technical, individual reimbursement decisions. The state reimbursement systems, rather than being central to the Medicaid program, will be reduced to nothing more than one piece of evidence used by litigants and the courts in contests over the reasonableness and adequacy of the States' reimbursement rates. Moreover, a decision of this Court authorizing dissatisfied providers to proceed directly into federal court would render the state administrative appeals procedures superfluous and the congressional mandate for them (42 U.S.C. § 1396a (a)(37)(B)) meaningless. See *Smith v. Robinson*, 468 U.S. at 1012 (precluding Section 1983 action for violation of the Education of the Handicapped Act in part because such a result would render provisions in the statute superfluous).

In sum, this Court has refused to assume that Congress intended to condition federal funds upon the States' incurring "largely indeterminate"²¹ obligations such as providing "reasonable and adequate" reimbursement rates. This principle has special applicability where, as here, Congress has mandated the type and scope of remedy that the States must provide for rate reimbursement challenges, and States, including Virginia, have expended funds to meet this requirement. See *Tennessee Valley Authority v. Hill*, 437 U.S. 153, 188 (1978) (applying maxim of *expressio unius est exclusio alterius*). Because imposing a Section 1983 remedy on the sufficiently comprehensive and congressionally mandated state remedies would impair the effectiveness of such remedies, this

²¹ *Pennhurst I*, 451 U.S. at 24-25 (using this phrase to describe the terms "appropriate treatment" and "least restrictive" setting).

Court should hold that respondent has no right of action under Section 1983 against Virginia.

Obviously, respondent, like the plaintiffs in *Smith v. Robinson* and *Sea Clammers*, would prefer to bring a Section 1983 action to remedy alleged violations of a federal statute and regulations rather than to seek relief through the review procedures required by the federal statute. The determinative inquiry, however, is not the wish of the plaintiff but the intention of Congress. See *Smith v. Robinson*, 468 U.S. at 1012 ("The crucial consideration is what Congress intended."). Virginia's federally mandated appeals system, together with the existing federal oversight of its state plan, is sufficiently comprehensive to evince a congressional intent to secure whatever rights are granted by the Medicaid Act through these remedial devices and to foreclose a Section 1983 remedy.

D. If Adopted By This Court, Respondent's Position Would Have Profoundly Adverse Consequences For Federal-State Relations And The Federal Courts' Caseload.

Respondent contends that, notwithstanding the provisions of the contract that it signed with DMAS, it is entitled to more money from Virginia because Virginia's rates are not "reasonable and adequate." Respondent's position is sufficient to ground a Section 1983 action only if this Court effectively rewrites the Medicaid Act, making the state plans, so carefully conceived as the linchpins of the Medicaid system, almost irrelevant. Several consequences would follow from such action by the Court. Most important, nearly every federal-state "cooperative program of shared responsibilit[ies] [will become] a device for the Federal Government to compel . . . State[s] to provide services that Congress itself is unwilling to fund." *Pennhurst I*, 451 U.S. at 22, citing *Harris v. McRae*, 448 U.S. at 309 (describing the Medicaid program). But Congress did not intend "cooper-

tive federalism"²² to become federal co-option of the States' sovereignty.

If the judgment below is affirmed, it is readily foreseeable that a large number of providers dissatisfied with reimbursement rates will follow the path of the VHA to the perceived haven of the federal district court—particularly with the vision of 42 U.S.C. § 1988 attorney's fees ahead. The resulting burden on limited state resources and crowded federal dockets would be further compounded because rate reimbursement decisions are not one-time events. The current number of such cases, itself impressive, would be just the beginning.²³ These cases,

²² *Harris v. McRae*, 448 U.S. at 308 (quoting *King v. Smith*, 392 U.S. at 316).

²³ In addition to this case, there are at least twenty-three pending cases challenging state reimbursement rates or appeals systems under Section 1983. These cases are listed in Appendix B of the amicus brief submitted by thirty-seven States in support of Virginia's petition for certiorari. Two of the cases cited in Appendix B as pending have now been decided: *West Virginia Hosps., Inc. v. Casey*, 885 F.2d 11 (3d Cir. 1989); *Amisub (PSL), Inc. v. Colorado Dep't of Social Servs.*, 879 F.2d 789 (10th Cir. 1989). In addition to these two cases, at least twelve other identical or similar cases have also already been decided: *Colorado Health Care Ass'n v. Colorado Dep't of Social Servs.*, 842 F.2d 1158 (10th Cir. 1988); *Coos Bay Care Center v. Oregon Dep't of Human Resources*, 803 F.2d 1060 (9th Cir. 1986), cert. granted, 481 U.S. 1036, vacated as moot, 484 U.S. 806 (1987); *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291 (8th Cir. 1985), cert. denied, 479 U.S. 1063 (1987); *United Hosp. Center, Inc. v. Richardson*, 757 F.2d 1445 (4th Cir. 1985); *Agi-Bluff Manor, Inc. v. Reagen*, 713 F. Supp. 1535 (W.D. Mo. 1989); *Vantage Healthcare Corp. v. Virginia Bd. of Medical Assistance Servs.*, 684 F. Supp. 1329 (E.D. Va. 1988); *St. Tammany Parish Hosp. Serv. Dist. v. Department of Health and Human Resources*, 677 F. Supp. 455 (E.D. La. 1988); *Mary Washington Hosp. v. Fisher*, 635 F. Supp. 891 (E.D. Va. 1985); *Al-Charles, Inc. v. Heintz*, 620 F. Supp. 327 (D. Conn. 1985); *Arden House, Inc. v. Heintz*, 612 F. Supp. 81 (D. Conn. 1985); *Yapalater v. Bates*, 494 F. Supp. 1349 (S.D.N.Y. 1980), aff'd per curiam, 644 F.2d 131 (2d Cir. 1981), cert. denied, 455 U.S. 908 (1982); *Bethany Medical Center v. Harder*, 1987 WL 47845 (D. Ks. 1987).

moreover, will not be limited to Medicaid disputes. Numerous federal-state cooperative endeavors provide federal funds to the States for programs that are contained in state plans approved by a federal agency.²⁴ Federal courts would be inundated with Section 1983 claims brought by businesses and individuals participating in federally funded programs with complaints about the States' implementation of their own regulations.²⁵

The policy rationale for preventing respondents from bypassing state procedural structures flows from the system of "cooperative federalism" of which Medicaid is a part. See *Harris v. McRae*, 448 U.S. at 308. Pursuant to 42 U.S.C. § 1396a(a)(37)(B), Congress placed the responsibility for reviewing reimbursement decisions upon the States because they are best able to determine a schedule of rates. Through the technical expertise of administrative tribunals and their knowledge of local conditions and concerns, States are particularly suited to provide the type of fast, efficient review that serves the interests of providers as well as state Medicaid agencies.²⁶

²⁴ See, e.g., 16 U.S.C. § 460l-8(d) (Land and Water Conservation Fund program); 20 U.S.C. § 1205 (Adult Education program); 20 U.S.C. § 1413 (Education of the Handicapped program); 42 U.S.C. § 654 (Child Support Enforcement program). See *Maine v. Thiboutot*, 448 U.S. at 34-37 (Powell, J., dissenting) (appendix) for a more complete list of such programs.

²⁵ Thus, in addition to its deficiencies in stating a cause of action under Section 1983, respondent's complaint raises serious Eleventh Amendment questions. See *Pennhurst State School & Hospital v. Halderman*, 465 U.S. 89 (1984) ("Pennhurst II").

²⁶ In the closely related context of Medicare reimbursement, this Court held that, in light of Congress's intent that administrative procedures be used, the dissatisfied program participants before the Court had to avail themselves of their administrative remedies before proceeding into federal court. See *Heckler v. Ringer*, 466 U.S. 602 (1984). In deferring to Congress, the Court explained in words equally applicable to Medicaid reimbursement (*id.* at 627) (footnote omitted):

Congress must have felt that cases of individual hardship resulting from delays in the administrative process had to be

Rate reimbursement disagreements may be more cheaply resolved at the state level before they become expensive Section 1983 lawsuits. Moreover, because the State-provider relationship is ongoing, interests of long-term stability require a less contentious forum than the adversarial arena of a federal district court. Finally, federal court litigation compounds the States' costs, for the States would remain obligated to fund the administrative review process. In short, authorization of Section 1983 actions would produce a costly, duplicative system of dispute resolution.

This result cannot be permitted in light of the language of the Boren Amendment, its legislative history, and the relevant agency interpretation, all of which demonstrate that the Medicaid Act does not confer on providers any substantive right secured by federal law.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be reversed.

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balanced against the potential for overly casual or premature judicial intervention in an administrative system that processes literally millions of claims every year. If the balance is to be struck anew, the decision must come from Congress and not from this Court.

(5)

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No. 88-2043

In The
Supreme Court Of The United States

OCTOBER TERM, 1988

GERALD L. BALILES, ET AL.,
Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

BRIEF AMICI CURIAE OF THE STATES OF CONNECTICUT,
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DELAWARE, FLORIDA, GEORGIA, HAWAII, IDAHO, ILLINOIS,
INDIANA, IOWA, KANSAS, KENTUCKY, LOUISIANA, MAINE,
MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA,
MISSISSIPPI, MISSOURI, MONTANA, NEVADA,
NEW HAMPSHIRE, NEW JERSEY, NEW MEXICO, NEW YORK,
NORTH CAROLINA, NORTH DAKOTA, OHIO, OKLAHOMA,
OREGON, PENNSYLVANIA, RHODE ISLAND,
SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, TEXAS,
UTAH, VERMONT, WASHINGTON, WEST VIRGINIA and
WYOMING IN SUPPORT OF THE PETITIONER
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In The
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OREGON, PENNSYLVANIA, RHODE ISLAND,
SOUTH CAROLINA, SOUTH DAKOTA, TENNESSEE, TEXAS,
UTAH, VERMONT, WASHINGTON, WEST VIRGINIA
and WYOMING

INTRODUCTION

The States of Connecticut, Alabama, Alaska, Arizona, California, Colorado, Delaware, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Washington, West Virginia and Wyoming (hereinafter the "Amici States") submit this brief in support of the Petitioner Commonwealth of Virginia. The decision of the Fourth Circuit in *Baliles v. Virginia Hospital Association*, 868 F.2d 653 (4th Cir. 1989), should be reversed.

QUESTION PRESENTED

Whether the Medicaid statutes give health care providers (i.e., hospitals and nursing homes) a private right of action enforceable through 42 U.S.C. § 1983 (1982) to challenge state reimbursement decisions in federal court.

INTEREST OF AMICI CURIAE

The State of Connecticut et al. submit this brief as amici curiae in support of the petitioner in this case, Commonwealth of Virginia. Virginia seeks reversal of the decision of the United States Court of Appeals for the Fourth Circuit in *Virginia Hospital Association v. Baliles*, 868 F.2d 653 (4th Cir. 1989). In urging the Court to reverse the decision of the circuit below, the State of Connecticut is joined by 45 additional states.¹ The amici states, individually and collectively, have an overriding interest in the question presented in this case: whether health care service providers have a right enforceable through section 1983 to sue in federal court for a particular level of Medicaid reimbursement.

This case presents the same issue on which this Court granted certiorari in *Coos Bay Care Center v. Oregon*, 803 F.2d 1060 (9th Cir. 1986), cert. granted, 481 U.S. 1036, judgment vacated and remanded on issue of mootness, 484 U.S. 806 (1987) (Coos Bay): Did Congress intend to permit providers of health care services under 42 U.S.C. § 1396a(a)(13)(A) (1986) to bring suit against the states under 42 U.S.C. § 1983 (1982) when it amended the Medicaid statutes in 1980? The issue is no less important today than it was in 1987 when a majority of the states, several organizations representing local governments, and the United States Solicitor General all joined Oregon in requesting this Court to reverse the decision of the Ninth Circuit Court of Appeals allowing providers to sue. Indeed, the rapid growth of litigation in the area and the enormous amounts of money at stake bear stark witness to the Court's prudence in agreeing to hear that case and the ever-increasing importance to the States of the decision in this case.

¹ This brief of amici curiae is filed pursuant to Rule 36.4 of the Rules of the Supreme Court. Amicus State of Arizona does not participate in the Medicaid program directly. However, it participates in a cooperative state-federal program under a special grant that provides funds for indigent health care. Because of the similarities between this special grant program and the Medicaid program, Arizona has an interest in the issues presented in this case.

The number of challenges to state reimbursement systems by providers of inpatient hospital and long-term care services to Medicaid recipients has been substantial in recent years.² Each of these challenges has the potential to involve very large amounts of money drawn from both state and federal treasuries.³ Because the total number of state and federal dollars paid annually through medical assistance programs is truly staggering, the burgeoning number of cases has the potential to subject federal and state governments to liability running easily into the hundreds of millions of dollars.⁴

Medicaid is a voluntary, cooperative federal-state program that provides funds to reimburse certain costs of medical treatment for the needy. Each of the amici states participates in the Medicaid program, except Arizona. See footnote 1. As required by federal law, a participating state's Medicaid program must fund institutional medical care, including care in inpatient hospitals, nursing facilities, and intermediate care facilities (collectively referred to as "providers"). The amount

² See Appendix A for a representative sample of section 1983 challenges to Medicaid reimbursement rates which was appended to the brief of thirty-seven states as amici curiae concerning the Petition for Certiorari in this case.

³ For example, *Volk, et al. v. Oregon, et al.*, cited in Appendix A, although involving only one year's reimbursement schedule and involving the nursing home industry but not hospitals, has over \$5 million at stake, more than \$3 million of which is federal money. The several Pennsylvania cases may entail liability of \$80 million.

⁴ As the United States Solicitor General noted in his brief in support of the State of Oregon in *Coos Bay*, the federal contribution to the Medicaid program for medical assistance totalled \$23.4 billion in 1986. Brief For The United States As Amicus Curiae Supporting Petitioners, at 2, citing HEALTH CARE FINANCING ADMIN., DEPT OF HEALTH AND HUMAN SERVICES, MEDICAID FINANCIAL REPORT: FISCAL YEAR 1986. Federal funds comprised at least 50 and in some cases more than 70 percent of each state's medical assistance program in 1986. 49 Fed. Reg. 46,957 (1984). The average figure was approximately 58 percent. Thus, treating 1986 as a representative year, and including the states' contribution, the total medical assistance budget is over \$40 billion per year.

of federal-state dollars directed to needy persons through private, for-profit providers is a major portion of the overall Medicaid program.

The amici states have a substantial financial stake in the outcome of this case and a significant legal interest in its resolution. The decision below holds that a health care provider may bring an action under section 1983 to challenge the provider reimbursement rate set by a state and approved by the federal government. Providers are thus free to attack, on a year-by-year and provider-by-provider basis, the "reasonableness" of each state's reimbursement rates. Every routine rate challenge may be made a federal case.

Many of the amici states already are caught up in the explosion of provider litigation based on alleged federal rights to specific levels of reimbursement. Indeed, some amici states are under siege by multiple lawsuits for different years, different classes of providers and inconsistent claims as to the rate allegedly guaranteed by federal law. Millions of state and federal dollars are potentially at stake in each lawsuit. Collectively, hundreds of millions of dollars are involved. The amici states therefore file this brief and urge the Court to reverse the decision of the circuit below.

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SUMMARY OF ARGUMENT

It is settled law that health care providers are not the intended beneficiaries of the Medicaid Act. Further, the better reasoned caselaw extends this settled principle of law to its next logical step, *to wit*, because providers are not the intended beneficiaries of the Medicaid Act, providers lack standing to sue state Medicaid agencies in § 1983 actions over alleged violations of said act.

In addition to lacking standing, Congressional intent, as revealed by the language and history of the 1980 amendments to the Medicaid statutes, refutes the circuit court's conclusion that the Medicaid statutes give providers a legally enforceable right to sue states over reimbursement rates under the aegis of section 1983. The Boren Amendment to 42 U.S.C. § 1396(a)(13)(A) provides only that states must provide "assurances" to the Secretary of Health and Human Services that rates are reasonable and adequate. There is no language in the amended statute suggesting enforceable rights. The history of the amendments confirms that Congress intended to decrease federal oversight of state rate-making. Layering federal judicial scrutiny on top of administrative and state court judicial review runs directly counter to that intent. Rather than reducing federal oversight of the state rate-making process and entrusting the states with primary responsibility for those rates, as Congress intended, the result below increases federal oversight and transfers primary rate-setting authority to the courts by means of § 1983 actions.

ARGUMENT

I. HEALTH CARE PROVIDERS ARE NOT THE INTENDED BENEFICIARIES OF THE SOCIAL SECURITY ACT.

The *amici* states respectfully submit that the point of departure for appropriate analysis of the question presented is the settled principle of law that the intended beneficiaries of the Social Security Act are the recipients of benefits and *not* health care providers. *Silver v. Baggiano*, 804 F.2d 1211, 1216-1217 (11th Cir. 1986); *Oberlander v. Perales*, 740 F.2d 116, 121 (2nd Cir. 1984); *Geriatrics, Inc. v. Harris*, 640 F.2d 262, 265 (10th Cir. 1981) (nursing home provider "is not the intended beneficiary of Medicaid program."); *Dialysis Centers, Ltd. v. Schweiker*, 657 F.2d 135, 139 (7th Cir. 1981) ("the statute manifests no Congressional intent to protect the financial interests of health care providers"); *Northlake Community Hospital v. United States*, 654 F.2d 1234, 1242 (7th Cir. 1981) ("The provider . . . is *not* the intended beneficiary of the Medicare program." (emphasis in original)); *Green v. Cashman*, 605 F.2d 945, 946 (6th Cir. 1979) ("We do not find in the statute authorizing Medicare and Medicaid any legislative intention to provide financial assistance to providers of care for their own benefit. Rather, the statute is designed to aid the patients and clients of such facilities."); *Cervoni v. Secretary of H.E.W.*, 581 F.2d 1010, 1018 (1st Cir. 1978) (physicians not intended beneficiaries under Medicare Program); *Case v. Weinberger*, 523 F.2d 602, 607 (2nd Cir. 1975) ("A nursing facility's 'need' for patients has nothing to do with the statutory benefits structure. . . . The benefits to a nursing home from its participation in Medicaid reimbursement result from nothing more than a statutory business relationship."); *St. Joseph Hospital v. Electronic Data Systems*, 573 F.Supp. 443, 447 (S.D. Texas 1983) (case law "clearly establishes that providers are not the intended beneficiaries of the Medicaid Program."); *Thomas v. Johnston*, 557 F.Supp. 879, 903 (W.D. Texas 1983) ("[I]t is abundantly clear that it is

Medicaid recipients and not Medicaid providers who are the intended beneficiaries of the Medicaid program."); *In Re Park Nursing Center, Inc.*, 28 B.R. 793, 805 (Bankr. E.D. Mich., S.D. 1983).

To the contrary, health care providers are business entities that made the voluntary business decision to enter the Medicare or Medicaid Program. *St. Francis Hospital Center v. Heckler*, 714 F.2d 872, 875 (7th Cir. 1983), cert. denied 465 U.S. 1022 (1984) (Medicare); *Middletown Haven, Inc. v. Maher*, C.C.H. MEDICARE & MEDICAID GUIDE ¶34,249 (Conn. Super. Ct. 1984) (Medicaid).

It is self-evident that health care providers are no more the intended beneficiaries of the Medicaid Program than construction companies are the intended beneficiaries of government appropriations to build elementary schools. Rather, both are businesses participating in government programs designed to assist those in need.⁵ If a health care provider is dissatisfied with his future anticipated rate levels, his remedy is to not renew his contract (provider agreement) with the government and to leave the Medicaid Program. *Minnesota Assoc. of Health Care Facilities v. Minnesota Dept. of Public Welfare*, 742 F.2d 442, 446 (8th Cir. 1984), cert. denied, 469 U.S. 1215 (1985), (providers are free to decline to participate in the Medicaid Program if they are dissatisfied with a state's rates).

⁵ Indeed, the law of the Second Circuit is that providers have no property interest in prospective reimbursement rates. *Oberlander v. Perales*, 740 F.2d at 120; *Grossman v. Axelrod*, 646 F.2d 768, 771 (2nd Cir. 1981). See also *Murthy v. Perales*, 1989 WL 19136, C.C.H. MEDICARE & MEDICAID GUIDE ¶37,818 (S.D.N.Y. 1989) ("the contractual nature of the relationship between a Medicaid provider and the State . . . indicate[s] that the provider's interest does *not* rise to the level of a constitutionally protected property interest." (Citing *Plaza Health Laboratories v. Perales*, No. 88-8939 (S.D.N.Y. 1989), aff'd 878 F.2d 577 (2d Cir. 1984) (emphasis in original))).

II. BECAUSE PROVIDERS ARE NOT THE INTENDED BENEFICIARIES OF THE MEDICAID ACT, PROVIDERS LACK STANDING TO SUE STATE MEDICAID AGENCIES IN § 1983 ACTIONS OVER ALLEGED VIOLATIONS OF SAID ACT.⁶

As demonstrated *infra*, it is undisputed that the express wording of 42 U.S.C. § 1396a(a)(13)(A) does not contain a specific grant of a private right of action and merely sets forth certain obligations of the state Medicaid agency to the Secretary of Health and Human Services for approval of state Medicaid plans. Indeed the only part of federal Medicaid law that addresses provider challenges to their Medicaid rates is 42 C.F.R. § 447.253, the federal regulation mandating that state Medicaid agencies establish an administrative appeals procedure for providers to contest Medicaid rate decisions.⁷ As state uniform administrative procedure acts generally afford judicial review of the record of agency final decisions, this results in state court judicial review as well.

As we turn to the issue of whether a third party, non-intended beneficiary provider possesses by implication an enforceable right under 42 U.S.C. § 1396a(a)(13)(A), the appropriate point of departure is *Cort v. Ash*, 422 U.S. 66, 78 (1975), which held that, in determining whether a private remedy is

⁶ As will be demonstrated herein, being an intended beneficiary is necessary to have enforceable rights in a statute. However, even when one is an intended beneficiary (which in this case providers are not), such status in and of itself does not establish enforceable rights. See *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981).

⁷ This evinces federal intent that provider challenges to Medicaid rates be confined to state administrative hearings and subsequent state court judicial review and not be brought in the form of § 1983 actions. See *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 147 ("[w]here a statute expressly provides a particular remedy, a court must be chary of reading others into it."); *Northwest Airlines, Inc. v. Transport Workers*, 451 U.S. 77, 97 (1981) ("The presumption that a remedy was deliberately omitted from a statute is strongest when Congress has enacted a comprehensive legislative scheme including an integrated system of procedures for enforcement").

implicit in a statute not providing one, the first relevant factor is whether the plaintiff is "one of the class for whose *especial* benefit the statute was enacted . . ." (emphasis in original).⁸

Two circuits have recently invoked this *Cort v. Ash* analysis to reject attempts to imply private rights of action in other sections of the Social Security Act. *Wehunt v. Ledbetter*, 875 F.2d 1558, 1563-1566 (11th Cir. 1989) (re: Title IV-D of the Social Security Act, 42 U.S.C. §§ 651 *et seq.*); *West Allis Memorial Hosp., Inc. v. Bowen*, 852 F.2d 251, 255 (7th Cir. 1988) (re: 42 U.S.C. § 1395nn(b)(2)(B) of the Medicare fraud portion of the Social Security Act). Those cases are most significant because, like § 1396a(a)(13)(A) in this case, both cases involved sections of the Social Security Act in which it was the government and not private parties charged with enforcement responsibility. See 875 F.2d at 1565; 852 F.2d at 255. The *West Allis* case, involving health care providers and the Medicare program, is of particular interest. In that case it was held that:

"[N]either . . . [the statute] nor its legislative history suggests that Congress intended to provide a private remedy to Medicare providers such as West Allis. . . . The Secretary is charged with the administration of the Medicare Program. . . . Where a statute is framed as a 'general prohibition or command to a federal agency,' as it is in the present case, a private right of action will seldom be implied [citations omitted] . . . it is the Government, and not private parties, which is charged with the enforcement of the Medicare program. . . ." 852 F.2d at 255.

⁸ As will be demonstrated herein, the failure of non-intended beneficiary health care providers to pass muster under the *Cort v. Ash* interest analysis with respect to § 1396a(a)(13)(A) deprives health care providers of standing. In addition, the issue of whether under § 1983 there is any secured right to enforce remains. Footnote 7 *supra*, Argument III *infra*, and the case of *Middlesex City Sewerage Auth. v. National Sea Clammers*, 453 U.S. 1 (1981), demonstrate that health care providers fail on the latter issue as well.

Turning to the question presented, substantial caselaw has evolved as to lack of provider standing to sue state Medicaid agencies in § 1983 actions over an alleged violation of § 1396a(a)(13)(A) due to lack of intended beneficiary status. *Vantage Healthcare v. Virginia Board of Medical Assistance Services*, 684 F.Supp. 1329, 1331-1332 (E.D. Va. 1988) ("A number of courts, drawing on the statutory language, have stated that the Medicaid Act was enacted for the express and special benefit of the individual recipients. Such courts have held that health care providers are not the intended beneficiaries of the Medicaid Act . . . [describing and rejecting case law permitting providers to bring such § 1983 actions on the basis of perceived "parallel interests" with Medicaid patients as] the extreme end of the spectrum."); *Al-Charles, Inc. v. Heintz*, 620 F.Supp. 327, 335 (D.Conn. 1985)

("To the extent that the plaintiff [nursing home] is alleging here that the Title XIX Medicaid program creates an entitlement program for providers of medical services, as distinguished from recipients of medical services, such a claim has no merit. . . . Finally, to the extent that the claim rests on the assertion that the plaintiff has some entitlement under the Medicaid program, is an intended beneficiary of the Medicaid program, or has some federally protectable property interest in reimbursement rates determined by the state under the Medicaid program, the claim is insupportable.");

Arden House, Inc. v Heintz, 612 F.Supp. 81, 84 (D. Conn. 1985) ("the test of a proper § 1983 claim is whether the claimant can 'demonstrate that it has suffered an injury by the administration of a joint federal-state cooperative program and was an intended beneficiary of that program.' [citation omitted]. (emphasis in original). . . . The defendants contend, and the Court finds, that under this analysis, Arden House is not an intended beneficiary of the Medicaid program."); *Almond Pharmacy, Inc. v. Mankowitz*, 587 F.Supp. 925, 927-928 (N.D. Ill., E.D. 1984) (provider's § 1983 action over Medicaid

payment dispute dismissed, with court distinguishing between welfare recipients' right to sue in federal court as opposed to health care providers who are not the intended beneficiaries of the Medicaid Act and whose claims of alleged violations of the State Plan are enforceable in the state court system); *Pennsylvania Pharmaceutical Ass'n v. Dept. of Public Welfare*, 542 F.Supp. 1349, 1355-1356 (W.D. Penn. 1982)

("Congress enacted Title XIX of the Social Security Act to provide health care for the poor and aged, not to subsidize or otherwise to benefit health care providers [citations omitted]. By design the Medicaid program is structured to provide needed medical services to the poor. . . . If a provider finds participation in the program unprofitable he should withdraw from the program [citations omitted]. . . . "[After finding a lack of standing in the providers' challenge to the sufficiency of Pennsylvania's reimbursement schedules, the District Court declared:] "The poor, not the health care providers, are the intended beneficiaries of the Medicaid Act. . . . Accordingly, we find that Congress did not vest the . . . [provider] plaintiffs with an interest to challenge a state's payment schedules on the ground that these payments are insufficient . . . ");

State Dept. of Public Welfare v. Bair, 463 N.E. 2d 1388, 1390-91 (Ind. App. 1 Dist. 1984), (wherein the Indiana Court of Appeals held that providers lack standing to challenge the reimbursement system since the Medicaid program was for the benefit of recipients and not for the benefit of health care providers. The Indiana Court of Appeals declared:

"[I]t is obvious that the purpose of the Medical Assistance program is to ensure qualified recipients receive needed medical care and prescription drugs. Any resulting benefit to the plaintiffs is merely incidental and bears no relationship to the purpose of the

program. It is clear the legislation here in question is not intended to serve as a welfare program for pharmacists [citations omitted]. The plaintiffs, therefore, have no standing.");

See also *Association of Seat Lift Manufacturers v. Heckler*, 619 F.Supp. 1570, 1571 (W.D. Mo., W.D. 1985) (Medicare providers lack standing to sue Secretary because providers not within "zone of interest" contemplated by Congress in enacting Medicare Act. Medicare Act not intended to subsidize providers).

The Amici states respectfully submit that the cases in this section constitute sound law which recognizes reality. The Medicaid Act was enacted to provide health care to the indigent institutionalized elderly, who *are* the intended beneficiaries, and not to enrich health care providers, who are *not* the intended beneficiaries of the Medicaid Program.

Not only are the providers, who are not the intended beneficiaries of the Act, in this case attempting to do something to which they are not legally entitled, but the ironic and socially disastrous results that would ensue if they succeed would be a nationwide disruption of the Medicaid Program via a flood of § 1983 actions against state Medicaid agencies and the resultant slowdown if not diversion of the valuable, scarce taxpayer dollars set aside for the care of Title XIX Medicaid patients, the true intended beneficiaries of the Medicaid Program.

III. NEITHER THE LANGUAGE NOR THE HISTORY OF SECTION 1396 SUPPORTS FINDING THAT PROVIDERS HAVE RIGHTS ENFORCEABLE THROUGH SECTION 1983.

In *Maine v. Thiboutot*, 448 U.S. 1 (1980), this Court held that the phrase "and laws" in 42 U.S.C. § 1983 (1982)⁹ must be read literally, so as to create under that section a private cause of action against state officials for violations of rights conferred by federal statutes. One year after *Thiboutot*, this Court "recognized two exceptions to the application of 1983 to statutory violations." *Middlesex County Sewerage Auth. v. Nat'l Sea Clammers Ass'n*, 453 U.S. 1, 19 (1981) (*Sea Clammers*), citing *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981) (*Pennhurst*). The Court held that a section 1983 action will not lie where (1) Congress has foreclosed private enforcement of the federal statute in the statute itself, or (2) the statute does not create "enforceable rights" under section 1983. *Sea Clammers*, 453 U.S. at 19; *Pennhurst*, 451 U.S. at 28; see also *Wright v. City of Roanoke Redevelopment & Housing Auth.*, 479 U.S. 418, 423-24 (1987) (*Roanoke*). Clearly, Congress did not intend to grant enforceable rights to providers of health care services when it amended the Medicaid statutes in 1980.

In *Pennhurst* the Court concluded that whether Congress intended to create rights enforceable under the aegis of section 1983 must be determined from the language and history of the act if the act does not expressly provide for such actions. In this case, the language is not the right- or duty-creating

⁹ 42 U.S.C. § 1983 (1982) provides, in pertinent part:

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress. . . .

language a court must find to support a claim of rights enforceable under section 1983. In addition, the legislative history demonstrates that Congress intended to increase state autonomy and decrease federal oversight in the Medicaid reimbursement rate-setting process.

A. The language of section 1396 is not rights-creating language.

The act under consideration in *Pennhurst* referred to "rights" accorded to the intended beneficiaries of the act and "obligations" on the part of the states. Despite that language, this Court concluded Congress had not intended to create enforceable rights against the states. Rather, the Court determined, the language in question was merely precatory, a "nudge" in Congress' preferred direction. *Pennhurst*, 451 U.S. at 19.

The language of section 1396a(a)(13)(A) is far less likely to be employed by a Congress desirous of creating enforceable rights than is the language at issue in *Pennhurst*. Section 1396a(a)(13)(A) does not contain a specific grant of a private right of action. See *Wehunt*, 875 F.2d 1558 (11th Cir. 1989) and *West Allis*, 852 F.2d 251 (7th Cir. 1988), analyzing similar such sections of the Social Security Act. Nor does it read like a statute designed to "dictate specifically what the relevant government officials may and may not do." *Edwards v. District of Columbia*, 821 F.2d 651, 656 (D.C. Cir. 1987). Far from containing "right- or duty-creating language," *Cannon v. University of Chicago*, 441 U.S. 677, 690 n.13 (1979), section 1396a(a)(13)(A) permits participating states to devise reimbursement rates "which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities. . . ." The statute also provides that these rates are to be set "in accordance with methods and standards developed by the State." By its terms, therefore, section 1396a(a)(13)(A) vests rate-making discretion

in the state, subject to the condition that it makes "assurances satisfactory to the Secretary." As the *Pennhurst* Court noted in the context of the statute at issue in that case, "[i]t is at least an open question whether an individual's interest in having a State provide . . . 'assurances' [to the Secretary] is a 'right secured' by the laws of the United States within the meaning of § 1983." 451 U.S. at 28. Indeed, if the statutory requirement of assurances by the states confers any right on providers, it is only the right to have those assurances provided to the Secretary. The provision of the assurances then engages the machinery of the Secretary's review. The Secretary examines the assurances, the rates and the supporting data to determine whether the rates meet the statutory standard. The providers' "right," if any, is the right to have the Secretary perform his or her duty and conduct the required review to ensure proper accountability, not the "right" to substitute themselves and the courts for the state, under the scrutiny of the Secretary, as rate-maker.

Thus, in *Pennhurst*, this Court did not find enforceable rights despite language of right and obligation. Here, by contrast, the court of appeals found enforceable rights despite the lack of right- or duty-creating language. This Fourth Circuit holding flies in the face of the limited language of "assurances" this Court has previously found questionable as the basis of "enforceable rights."

The lower court acknowledged that the statute at issue in this case, like the statute in *Pennhurst*, was enacted under the spending power of Article I, section 8, clause 1, of the United States Constitution. 868 F.2d at 657, n.3. *Pennhurst*'s insistence on clear legislative direction in spending power cases stemmed from the Court's concern that states be informed of their obligations in unambiguous terms when they enter into a voluntary, federally supported program.

[L]egislation enacted pursuant to the spending power is much in the nature of a contract. . . . The legitimacy of Congress' power to legislate under the

spending power . . . rests on whether the State voluntarily and knowingly accepts the terms of the "contract". . . . There can, of course, be no knowing acceptance if a State is unaware of the conditions or is unable to ascertain what is expected of it.

451 U.S. at 17 (citations omitted). The lower court believed this concern is "allay[ed]" in this case because the states undoubtedly knew they were agreeing to pay reasonable and adequate rates when they elected to participate in the program. 868 F.2d at 659. It is one thing to say the states knowingly bound themselves to pay reasonable and adequate rates under the supervision and control of the Secretary. However, it is quite another to say they knowingly agreed to defend expensive, time-consuming and disruptive litigation in state and federal courts brought by each disgruntled provider over every aspect of and change in their programs. To make a simple analogy, even a consumer who felt she had no real choice but to enter into a particular contract is entitled to know it has an attorney fees provision in it.

Providers are voluntary participants in the Medicaid program. See 42 C.F.R. § 447.204 (1985); *Minnesota Assoc. of Health Care Facilities v. Minnesota Dept. of Public Welfare*, 742 F.2d 442, 446 (8th Cir. 1984), cert. denied, 469 U.S. 1215 (1985) (providers are free to decline to participate in the Medicaid program if they are dissatisfied with a state's rates). Thus providers have the ability to opt out of the Medicaid program any time a state's rates are such that they believe it is not economically desirable to participate. Even so, as a condition to state participation, the Secretary requires each state to have in place an administrative appeals process through which providers may challenge reimbursement rates. 42 C.F.R. § 447.253(c) (1985). However, the Secretary, whose interpretation is entitled to "some deference," *Roanoke*, 479 U.S. 418, 427, expressly has rejected the call for private rights of action in the regulations adopted to implement the Boren Amendment on the ground that the statutes contained neither mandate nor authority to provide judicial recourse for

dissatisfied providers. 48 Fed. Reg. 56,052 (1983), see also Preamble to Final Rule, Medicaid Program; Payment for Long-Term Care Facilities and Inpatient Hospital Services, 48 Fed. Reg. 56,046 at 56,050 (1983).

B. The history of section 1396 supports a result directly contrary to that reached in the circuit court.

By the earlier reference to the increasing numbers of suits challenging state reimbursement rates, amici do not merely suggest the federal courts will be met with a flood of litigation, although those waters are unquestionably rising. The point, rather, is that year-by-year, provider-by-provider litigation over each aspect of each state's plan is becoming the rule, a reality manifestly inconsistent with Congress' unmistakable intent to reduce rather than increase federal oversight of the rate-making process. That intent is conspicuous in the legislative history of the 1980 amendments to the Medicaid statutes.

In 1980, in response to the "inherently inflationary" nature of the former "reasonable cost" standard, Congress enacted the Boren Amendment to the Medicaid statutes.¹⁰ S. Rep. 96-471, 96th Cong., 1st Sess. 28-29.¹¹ The amendment "represented a significant change in the federal [reimbursement] standard," offering the states an opportunity to effect "more stringent cost containment" while freeing them from excessive "federal oversight of [their] reimbursement methodologies." *Wisconsin Hospital Ass'n v. Reivitz*, 733 F.2d

¹⁰Now embodied in 42 U.S.C. § 1396a(a)(13)(A) (1986).

¹¹There was no Senate or House report accompanying the Boren Amendment in 1980. Floor discussion of the Amendment, however, makes clear that it was drawn from a bill reported the previous year by the Senate Finance Committee. See 126 Cong. Rec. 17,885-86 (1980). The Boren Amendment does not differ materially from the provision contained in the 1979 bill. See S. Rep. 96-471, *supra*, at 157-58. The text reported here is from the Senate report that accompanied the 1979 bill.

1226, 1228 (7th Cir. 1984). Congress chose to "give[] the States flexibility and discretion . . . to formulate their own methods and standards of payment." S. Rep. 96-471, at 28. By the same token, Congress intended "to reduce federal oversight of state reimbursement . . ." *Mississippi Hosp. Ass'n., Inc. v. Heckler*, 701 F.2d 511, 521 (5th Cir. 1983). While pointing out that the Secretary would continue to insist on "assurances . . . that the payment rates . . . are reasonable and adequate," Congress "expect[ed] that the Secretary will keep regulatory and other requirements to that minimum necessary to assure proper accountability, and not overburden the States and facilities with marginal but massive paperwork requirements." S. Rep. 96-471, at 29. It is distinctly ironic that a Congressional effort to reduce cumbersome federal oversight of state programs and to contain Medicaid costs has become the impetus for a mounting tide of litigation and potential liability.

In the opinion below, the Fourth Circuit Court of Appeals acknowledged that, in *Pennhurst*, this Court left no doubt that Congressional intent is the "touchstone" of enforceable rights inquiry. The lower court's discussion of that intent, however, is largely limited to statements that merely reiterate the statutory references to "reasonable and adequate" rates. See 868 F.2d at 658-59. The court acknowledged that the purpose behind the Omnibus Budget Reconciliation Act (OBRA), of which the Boren Amendment was a part, was to reduce the federal budget. The court ignored, however, the parallel and equally important intent of the Boren Amendment to reduce federal oversight of state programs. Refusal to acknowledge this central goal of the Boren Amendment spared the court the unenviable task of reconciling the inevitably more intrusive effects of piecemeal litigation with Congress' indisputable intent to increase state autonomy in ratesetting.¹²

¹² Rather than having to defend its rates once, before a federal administrative agency, the states will now be forced to defend piecemeal as each disgruntled facility or band of facilities looks for the most sympathetic forum. For example, the Commonwealth of Pennsylvania is currently embroiled in six separate challenges. See Appendix A.

Based on its conclusion that Congress "intended no close scrutiny by the Secretary [of Health and Human Services]" of assurances by the states, the court below reasoned that the only way to effectuate the "guarantee" of reasonable and adequate rates is to allow providers to bring suit. 868 F.2d at 659. This deduction is based on a faulty reading of Congressional intent and an unjustified denigration of the role of the Secretary. The *exclusive express enforcement mechanism* of § 1396a(a)(13)(A) is the Secretary's authority to approve or disapprove state Medicaid plans. The previously discussed *Wehunt* and *West Allis* circuit court decisions apply this Court's *Cort v. Ash* decision to similar sections of the Social Security Act that were construed to be exclusively enforced by the government and held not to create enforceable rights by private parties. 875 F.2d 1558 (11th Cir. 1989); 852 F.2d 251 (7th Cir. 1988).

The circuit court correctly noted that Congress intended that state assurances would be considered satisfactory in the absence of a formal finding to the contrary by the Secretary. However, the court ignored the equally plain Congressional insistence on "proper accountability" to ensure that payment rates are, in fact, reasonably adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with minimal state and federal quality of care requirements and insure access to health care by Medicaid beneficiaries. See S. Rep. 96-471, at 29. The court's suggestion that Congress intended the Secretary to become a mere rubber stamp for whatever rates the states might conjure up is inconsistent not only with these expressions of Congressional intent, but also with the Secretary's view reflected in the regulations issued to implement the Boren Amendment,¹³ and the

¹³ See, e.g., Preamble to Interim Final Rule, Medicaid Program; Payment for Long-Term Care Facility Services and Inpatient Hospital Services, 46 Fed. Reg. 47,964, 47,966 (1981). The regulations, as revised to meet the requirements of the 1980 amendments, require states to submit assurances at least annually and whenever they propose significantly to revise methods

(continued)

Secretary's actions in reviewing state plans. See, e.g., *Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291 (8th Cir. 1985), cert. denied, 497 U.S. 1063 (1987) (discussing Secretary's disapproval of part of Nebraska's plan for 1983-84).

Congress intended to decrease, not increase, federal oversight of the rate-setting process. To that end Congress cut back federal administrative supervision to a level it deemed adequate to ensure proper accountability. The court of appeals has undone Congress' balance by layering judicial scrutiny onto administrative oversight. Supervision by litigation will almost inevitably entail greater delay and disruption in the administration of state Medicaid plans than would result from oversight by the Secretary even under the more demanding pre-Boren Amendment requirements. Further, it simply makes no sense to conclude that Congress intended to decrease federal oversight by the executive branch agency with the expertise in the operation of the Medicaid program and instead sought to give an increased role to the federal courts of the judicial branch for oversight of the state rate-setting process for healthcare providers. That result is manifestly inconsistent with Congress' intent and therefore erroneous.

¹³ (continued)

for determining payment rates. When amending plans or submitting new ones, states must submit related information on short-term effects and, to the extent feasible, long-term effects, on availability of care, type of care furnished, extent of provider participation and the degree to which costs are covered in hospitals serving a disproportionate number of low income patients. The Health Care Financing Administration "will review the information a State submits with respect to these items to determine whether it is reasonable to justify acceptance of the State's assurance." *Ibid.*

CONCLUSION

There is no valid public policy reason for health care providers, who are not the intended beneficiaries of the Act, to disrupt the Medicaid Program through § 1983 actions against state Medicaid agencies. To the contrary, 42 C.F.R. § 447.253 provides providers with a viable, efficient administrative remedy with subsequent state court judicial review to pursue their Medicaid rate disputes. Further, § 1396a(a)(13)(A) vests the Secretary with exclusive enforcement power over states' assurances concerning their state Medicaid plans. Failure to reverse the underlying circuit decision would disrupt this federal regulatory scheme and only delay if not divert the delivery of Medicaid tax dollars to the intended beneficiaries of the Medicaid Program.

For the reasons stated above, this Court should reverse the underlying circuit decision.

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No. 88-2043

In The
Supreme Court Of The United States

OCTOBER TERM, 1988

GERALD L. BALILES, ET AL.,
Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

APPENDIX TO BRIEF OF AMICI CURIAE

APPENDIX A

PENDING LITIGATION AT TIME OF PETITION FOR WRIT OF CERTIORARI

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Idaho:

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Missouri:

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Supreme Court, U.S. FILED DEC 18 1989 JOSEPH F. SPANIOL, JR. CLERK
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**IN THE
SUPREME COURT OF THE UNITED STATES**

October Term, 1989

GERALD L. BALILES, et al.,
Petitioners,

vs.

THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

**ON PETITION FOR WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT**

**BRIEF FOR GRAY PANTHERS ADVOCACY COMMITTEE,
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No. 88-2043

IN THE SUPREME COURT
OF THE UNITED STATES

October Term, 1989

GERALD L. BALILES, et al.,

Petitioners,

vs.

THE VIRGINIA HOSPITAL ASSOCIATION,

Respondent.

ON PETITION FOR A WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FOURTH CIRCUIT

STATEMENT OF INTEREST

Pursuant to Supreme Court Rule 36,
counsel for the petitioners and respondents
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amici curiae. Their letters of consent
have been filed with the Clerk of the Court.

Amicus curiae Gray Panthers Advocacy Committee is an affiliate of the Gray Panthers, with members residing in seven States and the District of Columbia. A majority of the Advocacy Committee members receive benefits under the Social Security Act; the Committee's major focus is representing the interests of low-income elderly people. Health issues, especially access to services for low income, minority, and disabled individuals, are a priority for the Gray Panthers Advocacy Committee and for the Gray Panthers.

Amicus curiae National Citizens' Coalition for Nursing Home Reform is a fourteen-year old organization comprised of 300 local member groups and many individuals, including nursing home residents actively involved in nursing home reform and advocacy throughout the United States. Coalition members have a keen interest in

being able to assert the rights of nursing home residents under the Medicaid law in federal court.

Amici curiae Tammy Steeves and Evelyn Serrano are Medicaid recipients and named plaintiffs in a class action currently pending in a California District Court.

Clark v. Kizer, No. 87-1700-LKK JFM (E.D. Cal., filed Dec. 7, 1987). This suit has been brought pursuant to 42 U.S.C. § 1983 and concerns the severe unavailability of maternity and dental care for Medicaid beneficiaries in California. The class relies, in part, on Medicaid laws that require states to assure that Medicaid beneficiaries have access to health care providers at least to the extent such access is available for the general population.

See, e.g., 42 C.F.R. § 447.204.

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SUMMARY OF ARGUMENT

This case concerns Title XIX of the Social Security Act, commonly called the Medicaid Act. 42 U.S.C. § 1396a et seq. The Court is being asked to decide whether the Medicaid Act, particularly 42 U.S.C. § 1396a(a)(13)(A), confers on health care providers an enforceable right under 42 U.S.C. § 1983 to challenge the adequacy of state Medicaid reimbursement rates to hospitals.

In their briefs, the Petitioner and National Governors' Association imply that beneficiaries, as well as providers, cannot sue under 42 U.S.C. § 1983 to enforce rights under the Medicaid Act. Petitioner's Brief ("Br.") at 12; National Governors' Association Br. at 13-14. This Court, however, should not reach the issue of

in already reached by the Court.

Summary points of the argument will be:

recipients' rights under 42 U.S.C. § 1983 (hereinafter "Section 1983"). This issue was not disputed below and goes far beyond the scope of the question on which the Court granted review. If, however, the Court chooses to review the question of recipients' rights, long-standing decisions by the Court leave no doubt that recipients can bring civil rights actions for violations of their rights under the Social Security Act.

Turning to the issue that is properly before this Court, amici urge the Court to uphold the hospitals' right under Section 1983 to enforce the rate provisions of the Medicaid Act. This independent right of enforcement is important because, without it, increasing numbers of providers will terminate participation in the Medicaid program. Medicaid provider participation is already reaching critically low levels in many parts of the country, particularly

in rural and inner-city areas. Placing restrictions on providers' ability to challenge their reimbursement rates will only exacerbate this problem.

ARGUMENT

I. RECIPIENTS HAVE THE RIGHT TO ENFORCE THE MEDICAID ACT UNDER SECTION 1983.

This case does not raise the issue of whether Medicaid recipients can sue under Section 1983 for violations of the Medicaid Act in general or the Boren Amendment in particular.^{1/} Of the four questions

^{1/} Petitioners mistakenly assert that this case raises the same issue as Coos Bay Care Center v. Oregon Dep't of Human Resources, 803 F.2d 1060 (9th Cir. 1986), cert. granted, 107 S.Ct. 1970 (1987), vacated and remanded on the issue of mootness, U.S., 108 S. Ct. 52 (1987). This earlier case raised the issue of whether Medicaid providers and their patients could bring a civil rights action for violation of the Boren Amendment.

originally raised by Petitioners, this Court only agreed to decide whether "a Medicaid provider [has a] private federal cause of action under 42 U.S.C. § 1983 to enforce [the] Medicaid Act against the State." 55 U.S.L.W. 3021, 3213. (Emphasis added.) This question for review does not fairly include the quite different and important issue of whether a Medicaid beneficiary can bring an action under Section 1983 for a state's violation of the Medicaid Act. See U.S. Sup.Ct. Rule 21.1(a). It would be particularly inappropriate for this Court to address any issues involving Medicaid recipients' rights in this case inasmuch as these issues were not raised in the court below. See Youakim v. Miller, 425 U.S. 231, 234 (1986); Delt. Air Lines, Inc. v. August, 450 U.S. 346, 362 (1981).

Unfortunately, however, the Brief of Petitioners (at 12) and the Brief of the

National Governors' Association, et al., as Amicus Curiae in Support of Petitioners (at 13-14) attempt to bootstrap the broader argument that no private party can bring a Section 1983 action to challenge violations of the Boren Amendment. Because they have interjected a new question which directly affects Medicaid beneficiaries' rights, amici curiae feel obligated to respond briefly on this subject.

The Medicaid program was established in 1965 to provide federal financial assistance to states for furnishing medical treatment to needy persons. Schweiker v. Hogan, 457 U.S. 569, 571 (1982). 42 U.S.C. § 1396 expressly authorizes federal funding to the states so that they will provide medical assistance to "families with dependent children" and "aged, blind or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services. . . ."

Regardless of the parties' differences in this case, there is at least agreement that recipients are the intended beneficiaries of the Medicaid Act. Indeed, Petitioners expressly argued in the Court of Appeals that recipients have enforceable rights under the Medicaid Act. Virginia Hospital Ass'n v. Baliles, 868 F.2d 653, 656 (4th Cir. 1989). So, too, 46 other states are now arguing in this Court that the only "intended beneficiaries of the Social Security Act are the recipients of benefits. . . ." Brief Amici Curiae of the States of Connecticut, et al., at 2-3 (and the cases cited therein); see also National Governors' Association Br. at 3 (Medicaid program "designed to provide health care services to the poor").

This Court has long recognized that beneficiaries can bring actions under Section 1983 to enforce their rights under

the Social Security Act. Maine v. Thiboutot, 448 U.S. 1, 4-8 (1980); Edelman v. Jordan, 415 U.S. 651, 675-677 (1974); Rosado v. Wyman, 397 U.S. 397, 420 (1970) ("We are most reluctant to assume Congress has closed the avenue of effective judicial review to those individuals most directly affected by the administration of its program"). Like the Aid to Families with Dependent Children program described in Rosado and Thiboutot, the Medicaid program is a cooperative federal-state program built around a state plan under which the state must meet numerous specific federal requirements. Compare 42 U.S.C. § 602(a) and (b) with 42 U.S.C. § 1396a(a) and (b).

Thus, this Court has decided several cases brought by Medicaid beneficiaries against state officials for alleged violations of the Medicaid Act. Atkins v. Rivera, 477 U.S. 154 (1986); Herweg v. Ray, 455 U.S.

265 (1982); Harris v. McRae, 448 U.S. 297 (1980).^{2/} In Blum v. Stenson, 465 U.S. 886 (1984), this Court also considered the related issue of how to determine an appropriate attorneys' fee award under 42 U.S.C. § 1988 for Medicaid recipients who had prevailed in their Section 1983 action against state officials.

Nevertheless, Petitioners and the National Governors' Association appear to argue that no private party, including a beneficiary, may bring a civil rights action for violations of the Boren Amendment.

Quite recently, this Court in Golden State Transit Corp. v. City of Los Angeles,

^{2/} The lower courts have also held that Medicaid recipients can bring suit under 42 U.S.C. § 1983. See, e.g., Weaver v. Reagen, 886 F.2d 194, 195 n.1 (8th Cir. 1989); Mitchell v. Johnston, 701 F.2d 337, 344 (5th Cir. 1983); Thomas v. Johnston, 557 F.Supp. 879, 902 (W.D.Tex. 1983) (upholding Section 1983 suit by Medicaid beneficiaries to enforce reimbursement provisions of 42 U.S.C. § 1396a(a)(13)(A)).

____ U.S. ___, 58 U.S.L.W. 4033 (U.S. Dec. 5, 1989), reiterated the two-part test for determining whether a particular violation of federal law falls within the broad coverage of Section 1983. First, the plaintiff must allege the violation of a federal right. Id. at 4034. Second, even where the plaintiff has asserted the violation of a federal right, the defendant may still demonstrate that Congress "specifically foreclosed a remedy" under Section 1983 by establishing a comprehensive enforcement mechanism for protection of this federal right. Id.

If the Court applies the two-part test in Golden State Transit Corp. to the Boren Amendment, 42 U.S.C. § 1396a(a)(13)(A), the legal issues nonetheless are quite different for beneficiaries than providers. For beneficiaries, their federal right rests upon the language in 42 U.S.C. § 1396a(a)(13)(A) that payment for hospital, skilled

nursing facility, and intermediate care facility services shall be through the use of rates "which the State finds, and makes assurance satisfactory to the Secretary, are reasonable and adequate to . . . assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality. . . ." (Emphasis added.)^{3/} Providers, on the other hand, have relied on other language in this statute as establishing their federal right to reasonable reimbursements for providing inpatient care.

Turning to the second part of the test for Section 1983 actions, the Court once

^{3/} In adopting the Boren Amendment, Congress did not intend "to encourage arbitrary reductions in payment that would adversely affect the quality of care." S. Rep. No. 139, 97th Cong. 2d Sess., reprinted in 1981 U.S. Code Cong. & Admin. News 744.

again must embark on a different analysis for recipients than providers as to whether the Boren Amendment, its legislative history, and HHS' implementing regulations, 42 C.F.R. §§ 447.250-447.280, were intended to create a comprehensive enforcement scheme in lieu of any remedies in federal court. The defendant in a Section 1983 action normally would bear the burden as to congressional intent. Golden State Transit Corp., 55 U.S.L.W. at 4034. Here, however, no party has assumed that burden or briefed this issue because, after all, beneficiaries did not bring this lawsuit. In sum, this case does not properly raise the question whether Medicaid beneficiaries, as opposed to providers, may sue under Section 1983 to enforce the provisions of the Boren Amendment.

**II. DENYING HOSPITALS RIGHTS
UNDER SECTION 1983 TO EN-
FORCE THE BOREN AMENDMENT
WILL ADVERSELY AFFECT
RECIPIENTS' ACCESS TO
HEALTH CARE.**

42 U.S.C. § 1396a(a)(13)(A) governs hospitals' reimbursement rates. Petitioners argue that providers' only mechanism to enforce this right is an administrative appeals process. 42 U.S.C. § 1396a(a)(37); 42 C.F.R. § 447.253(c). However, this administrative procedure is available only to resolve payment disputes between an individual provider and the state. It is not designed nor is it available to challenge the overall methodology of state reimbursement systems. Therefore, providers require access to the federal courts via Section 1983 in order to challenge states' unlawful reimbursement systems.

If hospitals are denied the right under Section 1983 to make these challenges, amici fear that hospitals will not accept Medicaid beneficiaries. Participation in the Medicaid program is purely voluntary; neither federal nor state Medicaid statutes require hospitals to admit Medicaid patients.^{4/} Moreover, providers are already at financial risk when they accept Medicaid patients. Except for nominal fees that may be charged to certain beneficiaries, Medicaid reimbursement -- whatever it may be -- must be accepted as payment in full. 42 C.F.R. § 447.15.

^{4/} The Medicare Act does require hospitals with emergency rooms to provide "stabilizing treatment" for emergency medical conditions and women in active labor. 42 U.S.C. § 1395dd. Furthermore, facilities that have accepted federal Hill-Burton grants and loans are required to participate in Medicaid. 42 C.F.R. § 124.603(c)(1)(ii).

~~Experience has shown that inadequate state reimbursement levels have, in many instances, presaged beneficiary access problems. Below, amici highlight some of these access problems to illustrate how any further disincentives to participation in the Medicaid program surely will result in diminished access for Medicaid beneficiaries.~~

1. Some Hospitals Serving Medicaid Recipients Have Gone Out of Business.

Approximately 300 public hospitals have closed since 1985. American Hospital Association, Hospital Closures 1980-1988 (January 10, 1989) (prepared by the AHA Hospital Data Center). Low Medicaid reimbursement has been a major factor leading to these closures. The situation in Chicago, Illinois is typical. There, severe limits on

reimbursement instituted under the Illinois Competitive Access and Reimbursement Equity ("ICARE") program contributed to the closure of eight hospitals in a three-year period. One such hospital, Mary Thompson Hospital, which depended on Medicare and Medicaid reimbursement for 80% of its patients, closed in the Spring of 1988. Several other hospitals reported that they were on shaky financial ground, as they "grapple[d] with too many Medicaid patients and not enough Medicaid funds." Carlsen, "Chicago Hospitals Faltering," Health Week, May 9, 1988, at 2, col. 2. A study of the ICARE system concluded that "the program places a greater importance on shaving dollars from hospital per diems in the short run. Clinical outcomes for patients served or long-range objectives for the hospital sector in Illinois seem less important, and this shortsightedness is the essence of the ICARE

program's shortcomings." Salmon, et al., "Reducing Inpatient Hospital Costs: An Attempt at Medicaid Reform in Illinois," 13 J. of Health Politics, Policy and Law 103, 120-21 (Spring 1988).

2. Some Hospitals Have Had
to Engage in Behavior
Aimed at Discouraging
Medicaid Recipients
From Obtaining Care.

Short of terminating participation in Medicaid, some hospitals have had to avoid Medicaid program losses by taking steps to discourage beneficiaries from seeking care at their facilities. For example, by closing obstetrical and emergency services, hospitals sever the primary entry points by which Medicaid beneficiaries ultimately obtain in-patient hospital care.^{5/}

^{5/} National Association of Public Hospitals, America's Health Safety Net: A Report on the (cont. p. 21)

a. Some Hospitals Have
Had to Close Emer-
gency Services.

Hospital trauma and emergency room closures are a growing problem nationwide. In Los Angeles, seven of the county's 23 trauma centers closed during the last three years. Spiegel, "Emergency Rooms in U.S. Listed in Critical Condition," Los Angeles Times, July 25, 1988, at 1, col. 1. Over the last two years, 15 hospitals in Los Angeles closed or downgraded their emergency rooms. Reinhold, "Crisis in Emergency Rooms: More Symptoms Than Cures," New York Times, July 28, 1988, at 1, col. 2. Last summer, inner city hospitals serving a heavily low income population threatened to

5/ (cont. from p. 20)

Situation of Public Hospitals in Our Nation's Metropolitan Areas at 16 (Oct. 1, 1987) (emergency rooms are the primary source of low-income patient admission to hospital care).

close their doors to ambulances. *Id.* Similarly, in Miami, seven of eight hospitals have terminated their agreements to serve as "designated trauma centers" in their service areas, leaving Jackson Memorial Hospital, a county hospital, to handle the huge emergency burden alone. *Id.* New York City physicians report that overcrowding in the emergency system is creating "medical gridlock." Spiegel, "Emergency Rooms in U.S. Listed in Critical Condition," *Los Angeles Times*, July 25, 1988, at 1, col. 1. Hospital officials in all of these states attribute the dilemma, in part, to inadequate Medicaid reimbursement. *Id.*; Reinhold, "Crisis in Emergency Rooms: More Symptoms Than Cures," *New York Times*, July 28, 1988, at 1, col. 2.

b. Some Hospitals Have
Had to Engage in
Obstetrical Diversion.

Another method hospitals use to avoid Medicaid losses is so-called "obstetrical diversion." Under these programs, hospitals reject, or limit services to, pregnant women on Medicaid.

According to testimony before the California Medicaid Assistance Commission, more than 46,000 babies will be delivered at Los Angeles public hospitals this year by a system that can safely deliver only 35,000 babies. Garcia, "Obstetric Care Crises at Hand for County," Los Angeles Times, November 29, 1989, at B1, col. 1. The hospitals attribute most of their problems to restrictions in the Medicaid hospital reimbursement system which have caused private hospitals to refuse maternity

care to eligible beneficiaries. Id. The situation has deteriorated so much that Los Angeles is now developing a plan to turn pregnant women away. Id.

Meanwhile, in adjacent Orange County, the University of California Irvine Medical Center has experienced a deficit for the fourth time in six years. Stein, "Poor Patients May Put UC Hospitals in the Red, Regents Told," Los Angeles Times, June 17, 1989, at 36, col. 1. Much of the problem is attributed to chronic Medicaid underfunding. Id. To address the deficit, the Medical Center has developed an "obstetrical diversion" plan in which the facility deploys security guards to prevent Medicaid recipients who are in labor from entering the hospital's emergency room. Garcia, "Obstetric Care Crisis at Hand for County," Los Angeles Times, November 29, 1989, at B1, col. 1.

Medicaid recipients in rural Scott County, Tennessee, have also experienced "obstetrical diversion." Perl, "Where are the Children Born?" Washington Post, July 5, 1988, at 16, col. 1. There, pregnant women who live just a mile from the local public hospital must obtain care two hours away in Knoxville. Id. The local hospital terminated services for routine deliveries in 1984, citing the cost of the service; about 60% of the people who use Scott County Hospital are on Medicaid. Id. When Scott County closed its doors to pregnant women, the public hospitals in neighboring Claiborne and Campbell Counties did the same. Id.

**3. Disproportionate Share
Hospitals Depend on
State Compliance With
Federal Law to Maintain
Financial Stability.**

The vast majority of low-income patients receive their medical care in public hospitals, typically located in inner-city and rural areas. Congressional Research Service, Medicaid Source Book: Background Data and Analysis at 455-56 (Nov. 1988).

According to the Medicaid Source Book, public hospitals serve a disproportionate number of low-income patients for two reasons. Id. First, private facilities in metropolitan areas avoid private subsidization of Medicaid losses by allowing the public hospitals to carry the burden of meeting the health care needs of low-income patients. Id. at 456. Second, public hospitals are often located in areas with high concentrations of Medicaid beneficiaries and therefore are

more accessible to them. *Id.* Indeed, studies show that only "a handful of facilities treat a very high proportion of Medicaid patients, while the rest treat relatively few." *Id.* Without these facilities, there are no other facilities waiting to fill the gap. Feder & Hadley, Cutbacks and Care to the Poor: Will the Urban Poor Get Hospital Care? at 3 (May 1983).

Because these hospitals bear the principal responsibility for delivering care to low-income patients, their financial stability is often precarious.

Medicaid Source Book at 455-456. According to an Urban Institute Report, approximately one-half of all public hospitals in the nation's 100 largest metropolitan areas operate at a deficit, despite governmental funding and private subsidies. National Association of Public Hospitals, America's Health Safety Net: A Report on the Situation

of Public Hospitals in Our Nation's Metropolitan Areas at iii (Oct. 1, 1987).

In 1981, Congress enacted as part of 42 U.S.C. §1396a(a)(13)(A), a requirement that states must make adjustments in Medicaid rates for hospitals that serve a disproportionate number of low-income patients. In enacting this section, commonly called the "disproportionate share provision," Congress recognized that these hospitals will not survive unless they are compensated adequately for delivering care to low-income persons. H.R. Rep. No. 158, 97th Cong., 1st Sess., at 294-96 (1981).

So far, the states' lack of compliance with the disproportionate share provision has been widespread, making rights of enforcement all the more important. After it was enacted, studies by the National Health Law Program in 1985 and by the Health Care Financing Administration in 1987 demonstrated

that the majority of states had failed consistently to implement the provision. S. Wilson, J. Waxman, "Restoring Meaning to the 'Disproportionate Number' Provision," 18 Clearinghouse Review 860 (Dec. 1984); Secretary of Health and Human Services, Report to Congress on Medicaid "Disproportionate" Hospitals (January 28, 1987).

In the Omnibus Budget Reconciliation Act of 1987, Congress tried to address this inadequate compliance by promulgating explicit standards regarding designation of and reimbursement to disproportionate share hospitals. Omnibus Budget Reconciliation Act of 1987, § 4112, Pub. L. No. 100-203, 101 Stat. 1330-148 (codified as amended at 42 U.S.C. § 1396a(a)(13)(A)). Nevertheless, in the history to the Omnibus Budget Reconciliation Act of 1989, Congress again remarked upon the states' sorry level of compliance. The House Committee noted that

a survey conducted by the Intergovernmental Health Policy Project in February 1989 revealed that the majority of states continue to fail to provide adequate reimbursement to disproportionate share hospitals. H.R. Rep. No. 247, 101st Cong., 1st Sess. at 481 (1989).

The disproportionate share provision is one of the few mechanisms that enables facilities to continue operations while accepting low-income patients. It is essential, therefore, that hospitals' rights to challenge states' compliance with the disproportionate share provision be preserved. Absent this right, disproportionate share hospitals have no other means to challenge unlawful state reimbursement systems. If public hospitals lose this ability to demand adequate rates, they may be unable to continue operating, and there will be no other facilities to fill the gap.

for low-income patients.

CONCLUSION

This Court should hold that hospitals have the right to enforce 42 U.S.C. § 1369a (a)(13)(A) of the Medicaid Act pursuant to Section 1983. If the Court finds that hospitals have no such substantive federal rights, however, it should make clear that the decision does not affect the well-established right of recipients to enforce the Medicaid Act through Section 1983.

December 15, 1989

Respectfully submitted,
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DEC 29 1989

(9)
JOSEPH F. SPANIOL, JR.
CLERK

No. 88-2043

IN THE
Supreme Court of the United States
OCTOBER TERM, 1989

GERALD L. BALILES, *et al.*,
Petitioners,
v.

THE VIRGINIA HOSPITAL ASSOCIATION,
Respondent.

On Writ of Certiorari to the United States
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BRIEF OF THE
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AMERICAN HOSPITAL ASSOCIATION, AMERICAN
ASSOCIATION OF HOMES FOR THE AGING,
NATIONAL COUNCIL ON THE AGING, INC.
AS *AMICI CURIAE* ON BEHALF OF RESPONDENT

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QUESTION PRESENTED

Whether 42 U.S.C. § 1983 affords hospitals and nursing homes participating in a State Medicaid program a cause of action against State Medicaid officials for violation of the federal standard for Medicaid reimbursement of such institutions?

(i)

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INTEREST OF *AMICI CURIAE*

Amici are an alliance of national organizations representing health care providers that participate in the Medicaid program, and recipients of medical assistance under that program. *Amici*'s shared interest in this case is their concern that States not adopt Medicaid Plans designed systematically to under-reimburse providers, and thereby jeopardize Medicaid recipients' access to quality health care. *Amici* recognize that assuring high quality hospital and nursing home services is a complex process, requiring the hard work and cooperation of many dedicated health care professionals and nonprofessional staff. *Amici* also know that there is a vital link between

the ability of providers to assure the availability to patients of high quality care and the adequacy of the payment they receive for such care. Because Medicaid dollars represent approximately 10 percent of the gross revenues of hospitals, and 43 percent of the gross revenues of nursing homes, *amici* believe that providers must have the means to assure that the federal standard for Medicaid reimbursement of such institutions is met by each State's Medicaid program.

Amicus American Health Care Association ("AHCA") and its affiliated State associations are the largest national trade association representing the long term care (nursing home) industry. AHCA is a private, voluntary, nonprofit federation of 51 affiliated State associations representing more than 10,000 nonprofit and for-profit long term care providers which care for over one million nursing home patients. Many such patients are funded under the Medicaid program, and Medicaid spends annually approximately \$40 billion (State and federal funds) on nursing home services for Medicaid recipients. Founded in 1949, AHCA remains dedicated to the promotion of standards for professionals in long term health care delivery and quality care for residents.

Amicus American Hospital Association ("AHA") is a private, voluntary, nonprofit, national trade association of hospitals whose mission is to promote the welfare of the public through leadership and assistance to its members in the provision of better health care and services. With approximately 5,500 institutional members, the AHA represents a majority of the nation's acute care hospitals. A significant majority of these hospitals participate in the Medicaid program. Because more than \$23 billion of services are provided by hospitals to Medicaid patients annually, the AHA is vitally concerned that the payment systems implemented by the States provide rates that are adequate to guarantee access to quality medical care for those served through the Medicaid program.

Amicus American Association of Homes for the Aging ("AAHA") and its affiliated State associations are a national nonprofit trade association representing over 3,500 not-for-profit facilities providing health care, housing, continuing care retirement programs, and community services to more than 500,000 older individuals. Seventy-five percent of AAHA homes are affiliated with religious organizations; the remaining are sponsored by private foundations, fraternal organizations, government agencies, unions and community groups. With strong community involvement and long-standing community ties, AAHA members are committed to meeting the physical, social, emotional and spiritual needs of their residents in a manner which enhances each resident's sense of self-worth and dignity. Most of the members represented by AAHA and its 37 State affiliates participate in the Medicaid program.

Amicus National Council on the Aging, Inc. ("NCOA"), founded in 1950, is a national, nonprofit organization. Its membership includes individuals, voluntary agencies and associations (social, health, education, housing, religious, civic, etc.), business organizations and labor unions united by a commitment to the principle that the nation's older people are entitled to lives of dignity, security, physical, mental and social well-being and to full participation in society. NCOA conducts research, undertakes demonstration programs, sets standards, disseminates information and promotes the development of a continuum of opportunities and quality services with, by, for, and to older persons. NCOA has over 7,000 members, including nonprofit adult daycare programs, community-based long term care organizations, senior housing sponsors and other providers of services to the elderly.

The decision of the Court of Appeals in this case, recognizing that the Medicaid statute does not withdraw from hospitals and nursing homes a cause of action under 42 U.S.C. § 1983, allows health care providers the essential right to sue State Medicaid officials to vin-

dicate the right to reimbursement through payment rates that satisfy the federal standards contained in the Medicaid statute. Without the opportunity for federal judicial review, the quality of care that hospitals and nursing homes are able to provide is likely to suffer in many States. Because they believe that this result would be contrary to the purposes of the Medicaid statute and to the best interests of Medicaid recipients, *amici* wish to present their views concerning the important issues presented by this case.¹

BACKGROUND ON THE MEDICAID PROGRAM AND STATE RATESETTING METHODOLOGIES

A. The Medicaid Program

Medicaid is a cooperative federal-State program whose purpose is to provide federal funding to States to assist them in furnishing medical assistance, rehabilitation, and other services to the indigent. 42 U.S.C. § 1396 (1982 & Supp. 1987). Like other federal-State programs, States may choose between complying with the conditions of the statute or foregoing federal funding. To participate in the program, a State must first establish a State Plan for medical assistance ("State Plan"). *Id.* The State Plan is defined by regulation as a comprehensive written statement that describes the nature and scope of the State's Medicaid program and conforms with the requirements of the Medicaid statute, regulations, and other official issuances of the Department of Health and Human Services ("HHS"). 42 C.F.R. § 430.10 (1988).

The federal statutory requirements that a State Plan must meet are set forth in section 1902 of the Social Security Act. 42 U.S.C. § 1396a (1982 & Supp. 1987). The operative language of section 1902 is mandatory—the section begins with the statement, "A State Plan for medical assistance must provide . . .," and proceeds to enumerate 50 requirements. Among these requirements is

¹ Pursuant to Rule 36 of the Rules of this Court, the parties have consented to the filing of this brief. The parties' letters of consent have been filed with the Clerk of the Court.

the federal standard for reimbursement of hospitals and nursing homes, commonly known as the Boren Amendment. 42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. 1987).² This provision states that:

a State Plan for medical assistance *must* provide for payment . . . of the hospital services, skilled nursing facility, and intermediate care facility services . . . provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary [of HHS], are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality.

Id. (emphasis supplied).

At the federal level, Medicaid is administered on behalf of HHS by the Health Care Financing Administration ("HCFA"). HCFA regulations implementing the Boren Amendment require that the State Plan specify comprehensively the methods and standards used by the State Medicaid agency to set payment rates that are consistent with federal Medicaid requirements. 42 C.F.R. § 447.252 (1988). In addition, executing the statutory mandate, the regulations require that the State make certain findings on an annual basis, and whenever it submits a Plan or amendment for approval. 42 C.F.R. § 447.253(b) (1988). Among the findings required is that the State

² Section 1902(a)(13)(A) of the Social Security Act. Congress originally applied the Boren Amendment only to nursing homes in the Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 962 (1980). The new payment standard was extended to hospital services in the Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-248, § 2173 (1981). Congress has made clear that its intentions regarding the payment standard in the hospital amendment are identical with respect to the nursing home amendment. S. Rep. No. 139, 97th Cong., 1st Sess. 478 (1981).

pays hospitals and nursing homes rates that comply with the Boren Amendment standard. 42 C.F.R. § 447.253(b) (1) (1988).

The State is also required to provide assurances satisfactory to HCFA that it has made the requisite findings, 42 C.F.R. § 447.253(a) (1988), and that it provides an administrative appeals procedure. 42 C.F.R. § 447.253 (a), (c) (1988). States are not required to submit the findings themselves, or supporting data, for review. HCFA's review thus does not determine whether a State's Plan in fact complies with the Medicaid statute's substantive standards, but is limited to determining whether the State has submitted satisfactory "assurances" of its compliance with those standards. Pursuant to these authorities, all States have opted to participate in Medicaid, as has the District of Columbia.⁸

B. Enforcement of State Plans

HCFA regulations provide two basic means through which HCFA is permitted to enforce the obligations that the statute places upon participating States. First, in order to receive federal funding, every State Plan, and every amendment to a State Plan, must be approved by HCFA, which is authorized to disapprove those Plans that do not meet federal requirements. 42 C.F.R. §§ 430.12-430.15 (1988). Second, even after a Plan has been approved, HCFA has the authority to withhold federal payments to the State if HCFA finds that the State Plan, in operation and practice, does not comply with the requirements of section 1902, including the Boren Amendment. Specifically, the statute and regulations allow HCFA to withhold payment upon a finding:

⁸ The State of Arizona does not currently participate in Medicaid, but rather in a HCFA-sponsored demonstration project called the Arizona Health Care Cost Containment System. This program is the functional equivalent of Medicaid, and is treated herein as a Medicaid program.

- (1) that the plan has been so changed that it no longer complies with the provisions of section 1902 [section 1396a]; or
- (2) that in the administration of the plan there is failure to comply substantially with any such provisions.

42 U.S.C. § 1396c (1982 & Supp. 1987); see also, 42 C.F.R. § 430.35(a) (1988). The regulations further specify that "a question of noncompliance in practice may arise from the State's failure to actually comply with a Federal requirement, regardless of whether the Plan itself complies with that requirement." *Id.* at § 430.35(c).

In addition, the regulations require HCFA to perform "program reviews . . . [i]n order to determine whether the State is complying with the Federal requirements and the provisions of its Plan," *id.*, § 430.32(a), and States must correct their deficiencies. *Id.*, § 430.32(c). Although these provisions grant HCFA authority to terminate noncomplying States from Medicaid participation, the agency has never exercised this authority.

C. State Ratesetting Methodologies

The Boren Amendment grants States flexibility to fashion various reimbursement systems, as long as the federal standards spelled out in the statute are satisfied. While States have in fact adopted a variety of reimbursement systems, all are variations on one of two themes: specifically, they are either retrospective or prospective. In a retrospective system, the State sets interim rates that are adjusted after the end of the cost year based on the facility's cost report (a detailed financial statement) for that period. In a prospective system, rates are set based on an estimate of costs for a rate period, and there is generally no retrospective adjustment to account for actual facility costs during that period. By far the more common type of system, and the one at issue in this case, is the prospective system.

The hospital ratesetting methodology in Virginia's State Plan contains many elements found in other prospective

payment systems, and serves to illustrate the various components which make up such systems. See J.A. 24-45. See generally, *Mary Washington Hospital, Inc. v. Fisher*, 635 F. Supp. 891, 895-96 (E.D. Va. 1985) (describing operation of Virginia's system). Hospitals are categorized into peer groupings based on their number of beds and whether they are located in an urban or rural area.* For each group of hospitals, a reimbursement ceiling on operating costs was established for the initial rate period, based on cost data from the prior year (i.e., base year), adjusted for inflation with a "reimbursement escalator." Other States call this adjustment factor a "trend factor" or "inflation factor," but in any case, its purpose is to account for cost increases between the base year and the period during which the rates are actually paid.

In Virginia, the State also made further adjustments to account for wage differentials between various geographic areas throughout the State. These ceilings became the reimbursement limits for calculating individual facility rates. Each facility was entitled to a rate based upon its base year costs adjusted for inflation, but no facility could receive a rate higher than the ceiling. In subsequent years, the facility's rate continued to be computed by application of the trend factor to the base year costs, rather than by recalculating allowable costs.

The extent to which hospitals or nursing homes are reimbursed their actual costs thus may vary widely from State to State, and within a State, depending on the rate-setting methodology adopted in the State Plan. In every case, however, the State is required to make annual findings, and to assure HCFA, that the rates established by the chosen methodology are "reasonable and adequate to meet the costs which must be incurred by efficiently and

* Other factors sometimes considered by States in establishing hospital peer groupings are the age of the facility, teaching status, and the like. In setting nursing home rates, States may use similar groupings, and in addition, nursing homes are grouped by level of care provided, i.e., skilled nursing facilities and intermediate care facilities.

economically operated facilities" in order to make available quality care to Medicaid recipients. 42 U.S.C. § 1396a (a) (13) (A); 42 C.F.R. 447.253 (1988). The issue presented by this litigation is whether facilities have a right to sue State Medicaid officials under section 1983 to assure that the Plan's ratesetting methodology does not systematically fail to conform with this standard.

SUMMARY OF ARGUMENT

Beneficiaries of rights conferred by a federal statute have a cause of action under 42 U.S.C. § 1983 against State officials for violation of those rights. *Maine v. Thiboutot*, 448 U.S. 1 (1980). This rule permits the beneficiaries of a federal funding program to sue State officials for violations of federal funding requirements in their administration of the program, unless the defendants demonstrate either that: (1) Congress did not intend the statute at issue to confer "enforceable rights" on the plaintiffs; or (2) Congress did intend remedial devices required by the statute to constitute a comprehensive and exclusive scheme to remedy violations. *Wright v. City of Roanoke Redevelopment and Housing Authority*, 479 U.S. 418 (1987).

Under neither of these exceptions is there a basis for finding congressional intent to withdraw the section 1983 remedy from hospitals or nursing homes seeking to enjoin violations of the federal payment standard established by the Boren Amendment. The enforceable rights exception applies only where Congress speaks in merely precatory, rather than mandatory terms, or plainly does not intend the statute to confer rights on the putative plaintiffs. In the instant case, the payment standard set by the Boren Amendment is unequivocally mandatory, based on its plain language and because compliance with the standard is an express condition on the continued receipt of federal Medicaid funds. Moreover, the structure and legislative history of the Medicaid statute and the Boren Amendment indicate that Congress, recognizing an essential link between adequate reimbursement and quality of

care, intended the payment standard to benefit providers as a way of assuring the availability of quality services to Medicaid recipients.

Nor did Congress intend the administrative appeals procedures established by the States pursuant to HCFA regulations to represent a comprehensive scheme that would be the exclusive remedy for violations of the Boren Amendment. Not only is a comprehensive appeals requirement not directly mandated by the statute, but the regulations require only that States furnish an appeals or exceptions procedure to permit an individual provider an opportunity to present new evidence and receive prompt administrative review of its payment rate. HCFA has never suggested that the appeal procedures are intended for review of the legality of the State's ratesetting methodology, and the overwhelming majority of States, with the approval of HCFA, have adopted procedures that preclude such challenges. In short, there is no evidence that Congress intended the Medicaid statute as a comprehensive or exclusive remedial scheme, and the individual provider rate appeal regulation adopted by HCFA cannot change that intent.

Finally, the cursory nature of the review of State Plans that HCFA conducts makes a private cause of action essential to effective enforcement of the federal payment standard in the Boren Amendment. Lower court decisions invalidating State ratesetting methodologies for noncompliance with the Boren Amendment demonstrate the need for such a remedy. Several of these cases show that States have often implemented State Plans whose noncompliance with the statute is egregious. In the absence of a private cause of action to enjoin noncompliance, such Plans would operate to deny providers the reasonable and adequate reimbursement needed to assure the availability of quality care to Medicaid recipients.

ARGUMENT

RESPONDENT HAS A CAUSE OF ACTION UNDER 42 U.S.C. § 1983 AGAINST STATE OFFICIALS FOR VIOLATION OF THE FEDERAL MEDICAID REIMBURSEMENT STANDARD IN THE BOREN AMENDMENT

I. A SECTION 1983 ACTION EXISTS FOR VIOLATIONS OF FEDERAL STATUTORY RIGHTS UNLESS CONGRESS INTENDED NOT TO CONFER ENFORCEABLE RIGHTS UPON THE PUTATIVE PLAINTIFF, OR INTENDED A COMPREHENSIVE AND EXCLUSIVE REMEDIAL SCHEME IN THE ENACTMENT ITSELF TO SUBSTITUTE FOR SECTION 1983

In *Maine v. Thiboutot*, 448 U.S. 1 (1980), this Court held that beneficiaries of an entitlement created under the Social Security Act could sue State officials under 42 U.S.C. § 1983 for alleged deprivation of benefits conferred under the Act.⁵ Since *Thiboutot*, the Court has recognized two exceptions to the rule that section 1983 is available to remedy State violations of rights secured by federal statutes. See *Middlesex County Sewerage Authority v. National Sea Clammers Association*, 453 U.S. 1, 19 (1981), citing *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 67 (1981). A plaintiff alleging a deprivation of federal statutory rights by State officials will not be permitted to sue under section 1983 if: (1) the statute at issue is not the kind that creates enforceable "rights" under section 1983; or (2) Congress has

⁵ The program at issue in *Thiboutot* was Aid to Families With Dependent Children ("AFDC"), a federal-State cooperative funding program very similar to Medicaid. In both, the federal government contributes funds to be administered by a State agency in accordance with the terms of a State Plan approved by the supervising federal agency. Compare 42 U.S.C. § 602(a); 45 C.F.R. §§ 201.2-201.3 (AFDC), with 42 U.S.C. § 1396a(a); 42 C.F.R. §§ 430.10-430.15 (Medicaid). Like the plaintiffs in *Thiboutot*, Respondent seeks only a mechanism to compel State Medicaid officials to comply with statutory standards governing expenditure of program funds.

foreclosed private enforcement of the statute by creating a comprehensive and exclusive remedial scheme in the enactment itself. *Sea Clammers*, 453 U.S. at 19. The State defendants bear the burden of demonstrating, "by express provision or other specific evidence from the statute itself that Congress intended to foreclose private enforcement." *Wright v. City of Roanoke Redevelopment and Housing Authority*, 479 U.S. 418, 423 (1987).⁶

These exceptions are inapplicable in the instant case. The language, legislative history, and agency interpretation of the Boren Amendment amply demonstrate that it creates a right to "reasonable and adequate" reimbursement that is "enforceable" within the meaning of *Pennhurst*, and that the statute contains no remedial mechanisms that are sufficiently "comprehensive" to demonstrate that Congress intended to foreclose access to section 1983.

A. The Medicaid statute creates an "enforceable right" to provider reimbursement by rates that are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities

The first of the *Pennhurst* exceptions to section 1983 examines the statute, under which the plaintiff claims a right, to determine whether Congress intended that enactment to impose an "enforceable" obligation on the

⁶ Petitioners repeatedly mistake the object of the *Pennhurst* test as determining whether a cause of action under section 1983 is "implied." Pet. Br. at 7, 11, 17, 21, 22. Petitioners have confused *Pennhurst* analysis with that applied by the Court in determining whether a cause of action should be inferred from a silent federal statute. E.g., *Cort v. Ash*, 422 U.S. 66 (1975). In the latter case, a plaintiff must demonstrate that Congress intended by implication to confer a private right of action. Section 1983, however, is an express cause of action. The relevant inquiry is whether there is evidence that Congress intended to withdraw that cause of action in a particular case. See *Sea Clammers*, 453 U.S. at 26 (Stevens, J., concurring in part and dissenting in part); *West Virginia University Hosps., Inc. v. Casey*, 885 F.2d 11, 18 & n.1 (3d Cir. 1989).

State defendants. *Pennhurst*, 451 U.S. at 15. In the instant case, this inquiry has two components. First, the Court must ask whether Congress intended the interest in reasonable and adequate rates of payment to be mandatory, or whether Congress spoke "merely in precatory terms." *Id.* Second, if the statutory provision is a mandatory one, it must be asked whether the provision was intended to benefit Medicaid providers. *Golden State Transit Corp. v. City of Los Angeles*, No. 88-840, slip op. at 5 (U.S. Dec. 5, 1989).

1. In *Pennhurst*, the Court concluded that the patient "bill of rights" provision in the Developmentally Disabled Assistance and Bill of Rights Act of 1975 was merely a declaration of policy rather than a mandatory condition for participation in the program. The Court contrasted the Bill of Rights provision, which appeared in a section of the Act entitled "Findings," with other provisions of the Act entitled "conditions." 451 U.S. at 19, 23. While the failure of a State to meet one of the conditions of the Act could lead to the loss of federal funds, "funds [could] not be terminated for a State's failure to comply with" one of the "findings." *Id.* at 23. The distinction between conditions of receiving funds and mere findings of policy was critical, the Court explained, because only if Congress clearly "impose[d] conditions on the grant of federal funds" could "the States knowingly decide whether or not to accept those funds." *Id.* at 24. By contrast, in *Wright*, the statutory provision at issue was framed in "mandatory" terms, 479 U.S. at 430, and a failure to comply with that provision was enforceable by the termination of further federal funds. *Id.* at 424.

Pennhurst and *Wright* establish that a provision of a funding statute creates an enforceable right where that provision constitutes a *condition* of receiving federal funds, and where noncompliance with the provision would permit the administering federal agency to terminate further federal funding under the program. When the adminis-

trative agency retains that power, compliance with the federal standard is a "condition" on the continued receipt of such funds, and the condition is obviously enforceable within the meaning of *Pennhurst*. 451 U.S. at 23. The federal standard in the Boren Amendment is clearly a "condition" of participation. The Boren Amendment is one of 50 enumerated requirements of section 1902 which a State "must provide," and the failure to comply with any of these requirements is grounds for termination of federal funding.

Petitioners and the Solicitor General argue that because the Boren Amendment refers to rates that "the State finds, and makes assurances satisfactory to the Secretary, are reasonable," the obligations of the State are complete once the Secretary accepts the assurances. This interpretation elevates form over substance, and is therefore flatly inconsistent with the statute and implementing regulations. The Medicaid statute and regulations expressly distinguish between formal compliance and compliance in practice: "a question of noncompliance in practice may rise from the State's failure to actually comply with a Federal requirement, regardless of whether the plan itself complies with that requirement." 42 C.F.R. § 430.35(c); see 42 U.S.C. § 1396c; 42 C.F.R. § 430.35(a). The regulations further specify that a State must make annual findings that its payment rates are reasonable and must submit information related to the findings to HCFA. 42 C.F.R. §§ 447.250-447.255. There can be no doubt that if the Secretary determined, despite the State's "assurances," that the State's Plan operated in practice systematically to deny providers reasonable payment, HCFA would have the authority under the Medicaid statute to terminate federal funding. 42 U.S.C. § 1396c.⁷

⁷ The Solicitor General notes that in 1988 alone, \$29 billion in federal funds were expended under Medicaid. Br. of United States at 2. It is not credible that Congress would have committed the federal government to annual expenditures of this magnitude without intending that the responsible agency at least retain the ultimate

The legislative history confirms the plain language of the statute. While *amici* will not attempt to provide a comprehensive review of the legislative history, the following points are particularly significant.

First, when Congress enacted the Boren Amendment, it codified the requirement for reimbursement of the costs of "efficiently and economically operated" facilities already contained in HCFA regulations implementing the prior reasonable cost-related payment standard. See 45 C.F.R. § 250.30(a)(3)(iv) (1976). Legislative history regarding that prior standard—in which Congress observed that "providers can continue . . . to institute suit for injunctive relief in State or Federal courts, as necessary"—thus shows that Congress did not intend the Boren Amendment to withdraw the previously available section 1983 remedy. See H.R. Rep. No. 1122, 94th Cong., 2d Sess. 7 (1976); S. Rep. No. 1240, 94th Cong., 2d Sess. 4 (1976). Moreover, notwithstanding the greater flexibility granted to the States under the Boren Amendment, legislative history to that provision itself clearly indicates that "the Secretary [of HHS] is not expected to approve a rate lower than the applicable *legal requirements would mandate*." H.R. Rep. No. 1479, 96th Cong., 2d Sess. 154 (1980) (emphasis supplied). There is no evidence that, in enacting the Boren Amendment, Congress (which was well aware of Medicaid rate litigation in federal courts) intended to withdraw providers' right to initiate such litigation.

Congress has continued from time to time to express its view that the payment standard in the Boren Amendment is mandatory. For example, when Congress enacted extensive and costly nursing home quality of care reforms in the Omnibus Budget Reconciliation Act of 1987, it specifically directed that States must take those costs into

mate authority to expel noncomplying States from participation. The fact that HCFA has never exercised this draconian authority cannot be equated with an absence of congressional intent to grant it.

account in setting Medicaid rates. Pub. L. No. 100-203, 100th Cong., 1st Sess., § 4211(b) (1987). Moreover, Congress required special advance review by HCFA of State Plan amendments implementing these provisions. *Id.*; see also, H.R. Conf. Rep. No. 495, 100th Cong., 1st Sess. 703-704 (1987). Congress accomplished this without making any change in the underlying payment standard requiring "reasonable and adequate" rates. In addition, in enacting new federal minimum wage legislation this term, members of Congress confirmed the mandatory nature of the Boren Amendment's payment standard, stating that Medicaid "requires States to adjust their nursing home reimbursement rates to accommodate the increased costs that nursing homes [will] incur in complying with the increase in the minimum wage." 135 Cong. Rec. H7870 (November 1, 1989) (remarks of Representative Waxman, Chairman of Subcommittee on Health and Environment, House Energy and Commerce Committee) (emphasis supplied). See also, 135 Cong. Rec. S15249 (November 8, 1989) (remarks of Senator Hatch).

Accordingly, the Boren Amendment's federal payment standard is an "enforceable right" within the meaning of section 1983, as interpreted in *Pennhurst* and *Wright*.

2. Petitioners and their *amici* have argued that this case may be distinguished from *Thiboutot*, where the plaintiffs were a family eligible for AFDC benefits. Petitioners contend that the Medicaid statute was intended by Congress to benefit only the needy who receive medical care, not the health care providers who furnish that care. Petitioners' argument is at odds with the plain terms of the Medicaid statute, as well as its interpretation by HCFA.

The Medicaid statute makes hospitals and nursing homes direct beneficiaries of its payment provisions. First, in the case of hospitals and nursing facilities, payment is always made directly to the provider. See 42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. 1987); 42 C.F.R. § 447.250. See also, 42 C.F.R. § 447.253(c) (indi-

vidual provider has right to appeal its payment rate); 42 C.F.R. § 447.205 (1988) (public notice required of change in ratesetting methodology). Moreover, the Boren Amendment specifically emphasizes the need for States to establish rates adequate to permit "facilities" to meet their responsibilities to provide quality care and to afford reasonable access to Medicaid recipients. Thus, under the plain terms of the statute, providers are recognized "beneficiaries" of the Boren Amendment.

Providers' status as independent beneficiaries under the Medicaid statute is a necessary concomitant of the way the program is structured. *Amici* acknowledge that the fundamental purpose of the Medicaid program is to provide funds whereby States may arrange for the furnishing of medical assistance to the needy. But Congress recognized that this purpose could not be fulfilled without due regard for the providers' interest in adequate reimbursement. Thus, in the legislative history, Congress stated expressly that, although the Boren Amendment grants States greater flexibility in setting rates, the statute must not "encourage arbitrary reductions in payment that would adversely affect the quality of care." S. Rep. No. 471, 96th Cong., 1st Sess. 28-29 (1979). See also, 42 U.S.C. § 1396a(a)(22)(D) (1982 & Supp. 1987) (State Plan must specify standards and methods State will use to assure that services are of high quality); 42 C.F.R. § 440.230 (1988) (service must be of sufficient amount, duration, and scope reasonably to achieve its purpose).^{*} Thus, the effort to parse the interests of Medicaid recipients from those of providers is as inconsistent with congressional intent as it is with common sense.

* Numerous lower court decisions also have recognized this connection. *E.g.*, *Thomas v. Johnston*, 557 F. Supp. 879, 903-04 (W.D. Tex. 1983) ("[t]he link between the adequacy of reimbursement rates paid to providers and the adequacy of care provided to Medicaid recipients is quite obvious").

B. Congress has not foreclosed private enforcement of the Boren Amendment by providers in the Medicaid statute itself

The second *Pennhurst* exception to section 1983 examines the statute under which the plaintiff claims a right to determine if the enactment contains a remedial scheme "sufficiently comprehensive . . . to demonstrate congressional intent to preclude the remedy of suits under § 1983." *Sea Clammers*, 453 U.S. at 20. More precisely, the Court must inquire "whether Congress intended that the remedies in the substantive statutes be exclusive." *Id.* at 28 (Stevens, J., concurring in part and dissenting in part), citing *Pennhurst*, 451 U.S. at 28.

In only two cases has this Court found a statute's internal remedial schemes sufficiently comprehensive to demonstrate congressional intent to make the schemes exclusive. In *Sea Clammers*, the Court held that the "unusually elaborate enforcement provisions" of two federal water quality statutes, conferring private judicial remedies on citizens, evidenced congressional intent to preclude a section 1983 remedy. 453 U.S. at 13-14. A statutory right to judicial review was also available in *Smith v. Robinson*, 468 U.S. 992, 1011 (1984).

By contrast, the Court noted the complete absence of a private judicial remedy in concluding that the statute at issue in *Wright* was not intended to be exclusive. 479 U.S. at 427. The similar failure of Congress to provide any private judicial remedy under Medicaid strongly suggests the same result here. In fact, the Boren Amendment itself is silent as to the requirement of any private judicial or administrative remedies.*

* Amici the National Governors' Association *et al.*, erroneously argue that 42 U.S.C. § 1396a(a)(37)(B) requires States to establish administrative appeals procedures for providers. Br. of National Governors' Association, *et al.*, at 5. This section, which requires States to establish "procedures for prepayment and post-payment claims review" (emphasis supplied), by its plain terms has no bearing on provider appeal rights. Enacted as part of the Medicare and Medicaid Anti-fraud and Abuse Amendments of 1977,

Further, while Congress required HCFA to review and approve State Plans under the Boren Amendment, HCFA merely reviews the adequacy of the State's assurances, and under its own stated policies, does not conduct any meaningful in-depth review of a State's payment rates.¹⁰ This process can hardly be described as a comprehensive remedial scheme.¹¹ Moreover, many lower court decisions demonstrate that HCFA's cursory review of State "assurances" often results in approval of State Plans that manifestly do not satisfy the federal standard.¹²

As indicated, the Medicaid statute contains no requirement concerning provider appeals. While HCFA has

Pub. L. No. 95-142, § 2(b). This section relates to the *internal procedures* which States must establish to review specific claims to assure the medical necessity and quality of services provided to Medicaid recipients. It is especially revealing that HCFA, in adopting the regulations for limited appeals under the Boren Amendment, has not cited 42 U.S.C. § 1396a(a)(37)(B) as authority supporting this requirement. See 42 C.F.R. § 447.250. Thus, the effort to find congressional intent to establish a comprehensive review scheme rests on a statutory provision that is entirely inapplicable to the issue before the Court.

¹⁰ The cursory nature of HCFA's review of State "assurances" has often been documented in lower court decisions. See, e.g., *AMISUB (PSL) v. Colorado Dep't of Social Services*, 879 F.2d 789, 799 (10th Cir. 1989), *petition for cert. filed*, 58 U.S.L.W. 3322 (U.S. Oct. 25, 1989) (No. 89-682); *California Hosp. Ass'n v. Schweiker*, 559 F. Supp. 110, 116-117 (C.D. Cal. 1982), *aff'd*, 705 F.2d 466 (9th Cir. 1983).

¹¹ This review and approval process is nearly identical to that required under the AFDC regulations that were deemed insufficient to preclude a section 1983 action in *Thiboutot*. Compare 42 C.F.R. §§ 430.10-430.20 with 45 C.F.R. §§ 201.2-201.4.

¹² E.g., *California Hospital Ass'n v. Schweiker*, 559 F. Supp. at 115-17 & n.1 (6% cap on increases in rates, regardless of inflation); *Nebraska Health Care Association v. Dunning*, 778 F.2d 1291 (8th Cir. 1986) (HCFA approval of 3.75% inflation factor invalid due to failure of State to include "related information" required under regulations), *cert. denied*, 479 U.S. 1063 (1987); *Mary Washington Hospital, Inc. v. Fisher*, 635 F. Supp. 891, 904 (E.D. Va. 1985) (assurance that Plan contained adequate appeals system "simply not accurate").

adopted a limited appeals requirement, the HCFA regulation is further evidence that Congress did not require a comprehensive scheme for review of Plan deficiencies. Specifically, HCFA's regulation concerning provider rate disputes requires only that the State provide an appeals or exceptions procedure "that allows individual providers an opportunity to . . . administrative review, with respect to such issues as the agency determines appropriate, of payment rates." 42 C.F.R. § 447.253(c) (emphasis supplied). The regulation requires only that States create an administrative process for some types of claims and provide an assurance that such claims may be addressed administratively. Thus, in addition to the statute itself being silent, HCFA has not construed the statute as requiring States to establish a comprehensive appeal procedure for hospitals and nursing homes to contest the legality of a State's reimbursement methodology.

A survey of the Medicaid Plans of the 50 States and the District of Columbia confirms the absence of any intent to require such a comprehensive scheme. The limitations present in almost every State Plan make clear that broad-based challenges to the legality of the State's reimbursement methodology may not be raised in the administrative proceedings, which are designed to permit an individual provider to protest adjustments to its allowable costs and the specific rate set for it by the State agency.¹⁸

The most common limitations placed on rate-related provider appeals are those which limit review to the correction of errors in accounting or auditing data or procedures, and/or which permit rates to be revised only if changed circumstances since the base year have significantly elevated the individual provider's costs. Sixteen hospital and twelve nursing home appeal procedures are

¹⁸ A detailed narrative description of the administrative appeal procedures of these jurisdictions and citations to those procedures are contained in Appendix A. In Appendix B, we have classified the jurisdictions by certain relevant categories.

explicitly restricted in one or both of these ways.¹⁹ For example, in Illinois, a hospital may appeal its rate only for: (1) errors in calculation; (2) severe cash flow problems resulting from serving a disproportionate share of low income patients; or (3) significant "restructuring" since the base year, resulting in changes in required health or safety standards, adding or deleting beds or services, or making other capital changes causing specified cost increases. App. A-8 - A-9.

Several Plans (8 hospital, 5 nursing home) explicitly prohibit use of the provider appeals procedure for challenges to the legality of the State's methodology for rate determinations.²⁰ A typical example is Virginia's Plan for long term care, which states that "the principles of reimbursement are not appealable," and limits appeals to "the interpretation and application of those principles." App. A-26.

Another typical limitation (5 hospital, 4 nursing home) that precludes challenges to the legality of the ratesetting methodology is a prohibition on review of one or more key elements of the methodology.²¹ In the Virginia Plan at issue, for example, hospitals may not use the appeal procedure to challenge the State's method for determining peer groupings, the initial peer group cost ceilings or the annual inflation adjustment "escalator." J.A. 33; App. A-26. In Virginia, these elements are not only "key"—they represent the entire ratesetting methodology.

¹⁸ Hospital Plans: Arkansas, Colorado, Florida, Illinois, Indiana, Kansas, Kentucky, Maryland, Massachusetts, Mississippi, Montana, New Mexico, New York, Tennessee, Washington, Wisconsin. Nursing Home Plans: Alabama, Florida, Kansas, Maryland, Nebraska, Nevada, New York, South Carolina, South Dakota, Texas, Vermont, Wisconsin.

¹⁹ Hospital Plans: Alabama, Idaho, Michigan, Ohio, Pennsylvania, South Carolina, Texas, Wyoming. Nursing Home Plans: Idaho, Michigan, Pennsylvania, Virginia, Wyoming.

²⁰ Hospital Plans: California, Hawaii, Missouri, North Carolina, Rhode Island, Virginia. Nursing Home Plans: California, Hawaii, Missouri, North Carolina.

Another group of Plans (2 hospital, 6 nursing home) permit administrative appeals only to determine the conformity of a facility's rate with the "principles governing the determination of rates" set forth in the Plan or regulations. App. A-12.²¹ Four other States employ a similar limitation, permitting administrative review only of the "application" or "interpretation" of the principles in the Plan.²² ²³

Thus, in a significant majority of States, rate appeal procedures for hospitals (33 States) and nursing homes (34 States) clearly preclude providers from contesting the legality of the ratesetting methodology.²⁴ In most of

²¹ Hospital Plans: New Jersey, Georgia, Nursing Home Plans: Indiana, Maine, Massachusetts, Mississippi, New Jersey, New Mexico.

²² Nursing Home Plans: Colorado, New Hampshire, Kentucky, Rhode Island.

²³ Still other States impose restrictions that, while not expressly precluding review of the rate methodology, nevertheless must have that effect. One State requires that appeal of policy issues be brought within 30 or 35 days of the publication of the policy. App. A-3. Thus providers, who may not realize the negative impact that a particular ratesetting methodology will have until after costs are reported and rates are set for a given year, generally will be precluded from raising challenges to the legality of that methodology. Three other States require that appeals identify particular computations and adjustments, plainly indicating that the procedure is intended to be used for arithmetic, not legal, challenges. Hospital Plan: Nevada (appeal must also document adverse financial impact of rate). Nursing Home Plans: North Dakota and Utah.

²⁴ Hospital Plans: Alabama, Arkansas, California, Colorado, Florida, Georgia; Hawaii, Idaho, Illinois, Indiana, Kansas, Kentucky, Maryland, Massachusetts, Michigan, Missouri, Mississippi, Montana, Nevada, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, Wisconsin, Wyoming.

Nursing Home Plans: Alabama, Arkansas, California, Colorado, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Maine, Maryland, Massachusetts, Michigan, Missouri, Mississippi, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Pennsylvania, Rhode Island, South

the remaining States, the language of the State Plan or regulations is more ambiguous, but does not suggest that challenges to the ratesetting methodology would be permitted. Most States simply parrot the language of the federal regulation²⁵ or indicate merely that individual providers are permitted to appeal rates or rate determinations.²⁶ Absent explicit language to the contrary, there is good reason to assume that the designated administrative decisionmakers, whose role is to resolve individual rate disputes, do not have the authority to invalidate broader policies adopted by the State agency, even if those policies do not comply with federal law.²⁷

The number of States whose procedures appear to permit broad-based legal challenges is small indeed. Only eight States have enacted such procedures, and few of these unambiguously grant the right to challenge the legality of ratesetting methodology.²⁸

In sum, in addition to the fact that Congress has not mandated that States implement any provider appeal procedure (much less a comprehensive or exclusive one), review of the actual State procedures clearly demonstrates that even HCFA has not interpreted the Medicaid statute to evidence congressional intent to create a com-

Carolina, South Dakota, Texas, Utah, Vermont, Virginia, Wisconsin, Wyoming.

²¹ Hospital Plans: District of Columbia, Nebraska, Oklahoma, South Dakota, Utah. Nursing Home Plans: Louisiana, West Virginia.

²² Hospital Plans: Iowa, Louisiana, Maine, Oregon, Vermont. Nursing Home Plans: District of Columbia, Georgia, Illinois, Montana, Oklahoma, Oregon, Tennessee, Washington.

²³ See, e.g., *State Tax Comm'n v. Administrative Hearing Comm'n*, 641 S.W.2d 69, 75 (Mo. banc 1982) (administrative agency lacks authority to invalidate properly promulgated regulations: "[a]gency adjudicative power extends only to the ascertainment of facts and the application of existing law thereto").

²⁴ Hospital Plans: Alaska, Arizona, Connecticut, Delaware, Minnesota, West Virginia. Nursing Home Plans: Alaska, Arizona, Connecticut, Delaware, Iowa, Minnesota, Ohio.

prehensive remedial scheme that would encompass review of State ratesetting policies. Quite the contrary, HCFA's approval of Plans which typically preclude challenges to the ratesetting methodology further underscores the absence of congressional intent to foreclose access to other remedies.²⁵

Nor can HCFA's power to exercise the extreme sanction of terminating federal funding for a noncomplying Plan be regarded as part of a comprehensive review scheme. Although the courts have found that numerous State Plans violate the Boren Amendment, HCFA has never sought to terminate federal funding to a State on this basis. The Medicaid statute's purpose of enabling each State to provide medical assistance to the indigent would hardly be served by ejecting a State from participation. The benevolent goal of furnishing adequate medical care demands that some less extreme sanction, such as a section 1983 suit, be available to challenge a State's noncompliance with the Boren Amendment.

²⁵ In the *amicus* brief of the state attorneys general, it is argued that HCFA "expressly has rejected the call for private rights of action in the regulations adopted to implement the Boren Amendment on the ground that the [Medicaid] statute contained neither mandate nor authority to provide judicial recourse for dissatisfied providers." Br. of Amici State of Connecticut *et al.* This assertion is plainly wrong. In the regulatory preamble cited by the attorneys general, HCFA discussed comments received on "who should adjudicate appeals." 48 Fed. Reg. 56046, 56052 (1983). In response to one commentor's suggestion that HCFA should require States to "provide judicial recourse for providers dissatisfied with State payment rates," the agency correctly noted that the Medicaid statute did not grant HCFA authority to *require* such recourse. *Id.* In fact, the statute does not authorize HCFA to restrict or expand judicial review in any way. HCFA also concluded that the regulations did not restrict the right of providers to pursue State judicial remedies after exhausting the administrative process. *Id.* The agency expressed no view on the availability of a private cause of action under section 1983 or any other provision of federal law. *Id.*

II. RECOGNIZING A SECTION 1983 REMEDY WOULD NOT OPEN THE FLOODGATES TO FEDERAL COURT REVIEW OF INDIVIDUAL RATE DISPUTES, BUT WOULD PROVIDE A MEANINGFUL METHOD OF REMEDYING SYSTEMATIC VIOLATIONS OF THE BOREN AMENDMENT

A. Availability of a section 1983 remedy has not produced a flood of Boren Amendment litigation

Every United States Court of Appeals to rule on the question has held that Medicaid-participating health care providers have a right under section 1983 to sue State officials in federal court for Boren Amendment violations.²⁶ Despite this free access to the federal courts in the decade since the Boren Amendment was enacted, *amici* have discovered only 48 reported federal cases alleging violations of the Boren Amendment.²⁷ Slightly fewer than half of the federal cases were based on a section 1983 cause of action.²⁸ All involved challenges to the legality of the State's ratesetting methodology rather than individual rate disputes.

²⁶ West Virginia Univ. Hosps., Inc. v. Casey, 885 F.2d 11 (3d Cir. 1989); Virginia Hosp. Ass'n v. Baliles, 868 F.2d 653, 658 (4th Cir. 1989), cert. granted in part, 110 S. Ct. 49 (1989); Coos Bay Care Center v. Oregon Dep't of Human Resources, 803 F.2d 1060, 1062 (9th Cir. 1986), cert. granted, 481 U.S. 1036, vacated as moot, 484 U.S. 806 (1987); Nebraska Health Care Ass'n v. Dunning, 778 F.2d 1291, 1295 (8th Cir. 1985), cert. denied, 479 U.S. 1063 (1987); AMISUB (PSL) v. Colorado Department of Social Services, 879 F.2d 789, 798 (10th Cir. 1989), petition for cert. filed, 58 U.S.L.W. 3322 (U.S. Oct. 25, 1989) (No. 89-682). Cf. Yopalater v. Bates, 494 F. Supp. 1349, 1357-58 (S.D.N.Y. 1980) (finding right of action under prior reimbursement provision), aff'd per curiam, 644 F.2d 131 (2d Cir. 1981), cert. denied, 455 U.S. 908 (1982); Silver v. Baggiano, 804 F.2d 1211, 1217-18 (11th Cir. 1986) (reserving question).

²⁷ See Appendix C.

²⁸ In most of the other cases, the issue of whether a cause of action was available was not considered by the court. E.g., Alabama Hosp. Ass'n v. Beasley, 702 F.2d 955 (11th Cir. 1983).

While there have been a limited number of cases arising under section 1983, in the majority of the cases in which the court reached the issue of the legality of the ratesetting methodology, the court found the need to grant relief to prevent arbitrary or unlawful State action.²⁹ These cases demonstrate that the existence of a private cause of action permitting providers to challenge the legality of a State's ratesetting methodology has not produced a flood of litigation, and no reason exists to assume that a ruling by this Court upholding this right would increase significantly the number of such challenges.³⁰ Moreover, the success of many of these challenges is good evidence that this remedy is needed to assure State compliance with the standard contained in the Boren Amendment.

²⁹ See *AMISUB*, 879 F.2d 789; *West Virginia Univ. Hosps.*, 885 F.2d 11; *Nebraska Health Care Ass'n*, 778 F.2d 1291; *Washington State Health Facility Ass'n v. Washington Dep't of Social and Health Services*, 698 F.2d 964 (9th Cir. 1982); *St. Tammany Parish Hosp. Service Dist. v. Dep't of Health and Human Resources*, 677 F. Supp. 455 (E.D. La. 1988); *Children's Memorial Hosp. v. Illinois Dep't of Public Aid*, 562 F. Supp. 165 (N.D. Ill. 1983); *Illinois Hosp. Ass'n v. Illinois Dep't of Public Aid*, 576 F. Supp. 360 (N.D. Ill. 1983). Section 1983 has also been successfully used by Medicaid recipients to challenge a State's ratesetting methodology. *Montoya v. Johnston*, 654 F. Supp. 511 (W.D. Tex. 1987); *Thomas v. Johnston*, 557 F. Supp. 879 (W.D. Tex. 1983).

³⁰ Boren Amendment litigation is extremely costly and time consuming, due to the necessity of obtaining detailed expert and accounting reports establishing that the State's methodology will not result in efficiently and economically operated facilities receiving reimbursement approximating their actual costs. This requires analysis not only of an individual facility's costs, but those of all similar facilities in the State. See generally, Hamme & Kanner, *Long-Term Care Reimbursement Issues: Pro and Contra Aids for Litigants*, in 1989 *Health Law Handbook* (Clark Boardman Co., A. Gosfield, Ed. 1989). As a practical matter, it is not economically practicable for an individual provider to initiate Boren Amendment litigation simply to challenge its rate.

B. The absence of a remedy would permit State Plans which contain egregious violations of the Boren Amendment to continue in operation

To leave providers without a federal remedy for violations of the Boren Amendment would create the prospect of arbitrary or unlawful State action with no effective remedy and extremely significant consequences for hospital and nursing home providers and, hence, Medicaid recipients. As noted above, implementation of unlawful and inadequate rates will have an adverse impact on the quality of services provided to the vulnerable indigent population who require inpatient hospital or nursing home services covered by Medicaid. That States have implemented ratesetting methodologies which contain egregious violations of the Boren Amendment has often been documented in lower court cases.

Two recent circuit court decisions illustrate this problem graphically. In *AMISUB (PSL) v. Colorado Department of Social Services*, 879 F.2d 789 (10th Cir. 1989), *petition for cert. filed*, 58 U.S.L.W. 3322 (U.S. Oct. 25, 1989) (No. 89-682), the State implemented a Plan under which a hospital's base year Medicaid rate was determined by taking the average Medicare per diem reasonable cost per discharge for hospitals in a particular peer grouping, and multiplying that figure by .88. *Id.* at 791. The resulting figure then was multiplied by a "budget adjustment factor" of .54 to arrive at the Medicaid rate for each facility. *Id.*

In effect then, under Colorado's methodology, hospitals would receive a per diem rate for Medicaid patients that was less than half of the average cost that would be deemed reasonable by Medicare for the same patient. Expert testimony at trial established that under this system, no Colorado hospital, no matter how efficiently and economically operated, would be reimbursed its reasonable costs. *Id.* at 798-99.³¹ The court concluded that such

³¹ The court noted that while the State's "assurances" of adequate reimbursement might be "adequate for HCFA, . . . at trial a

a large across-the-board reduction, based solely on budgetary considerations, violated the Boren Amendment. *Id.* at 799.²²

Other ratesetting provisions may be equally violative of the Boren Amendment. In *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11 (3d Cir. 1989), the court was confronted with provisions in Pennsylvania's Plan, which computed rates for out-of-state hospitals providing care to Pennsylvania's Medicaid recipients differently than for in-state hospitals providing the same services. Rates for in-state hospitals were computed by taking an average cost per hospital stay (based on actual allowable costs) and adjusting that amount for each stay by a factor designed to account for the relative severity (cost) of the case. *Id.* at 16.

In contrast, rates for out-of-state hospitals were computed based not on allowable costs, but on the average of payments made to in-state hospitals (adjusted for severity). *Id.* In addition, out-of-state hospitals received lower reimbursement for capital costs, and no reimbursement for direct medical education expenses. *Id.* The district court found that this situation resulted in the plaintiff hospital receiving only 54 percent of its costs of treatment to Medicaid patients, as opposed to the 95 percent received by in-state hospitals. *Id.* at 25.

The Colorado and Pennsylvania Plans provide compelling examples of the potential for significant harm to hospitals and nursing homes, and ultimately to Medicaid recipients, that can occur where rates are predicated on

party must offer evidence which supports its position." *Id.* at 799. The court found no such evidence.

²² A smaller across-the-board reduction in nursing home rates, based solely on budgetary considerations, was invalidated in *Nebraska Health Care Ass'n v. Dunning*, [1984 Transfer Binder] Medicare & Medicaid Guide (CCH), § 34,100 (D. Neb. July 9, 1984) (reductions of 14.4% for intermediate care facilities and 4.4% for skilled nursing facilities), *aff'd in part and vacated in part on other grounds*, 778 F.2d 1291 (8th Cir. 1985) (State did not appeal invalidation of across-the-board reductions), *cert. denied*, 479 U.S. 1063 (1987).

budgetary or other constraints wholly unrelated to the health care needs of patients.²³ No one, and certainly not Congress in agreeing to provide funding for State Medicaid programs, could seriously expect hospitals and nursing homes to provide adequate care where reimbursement is set at one-half of the costs needed to provide quality services. Consequently, the courts, when confronted with these egregious cases, have appropriately concluded that such Plans fail to meet the statutory standard requiring rates that are adequate to permit efficiently and economically operated facilities to provide quality care.

Congress has repeatedly shown its concern about the need to maintain appropriate Medicaid funding for the poor and disabled, and there is no basis for concluding that Congress intended to insulate from meaningful scrutiny the types of unlawful payment reductions that occur when a State adopts a reimbursement methodology that flatly violates the State's obligations under the Boren Amendment. As this Court noted in *Rosado v. Wyman*, 397 U.S. 397 (1970), it is the duty of the federal courts, "no less in the welfare field than in other areas of the law, to resolve disputes as to whether federal funds allocated to the States are being expended in consonance with the conditions that Congress has attached to their use." *Id.* at 422-23. Under the scheme created by Congress, the appropriate mechanism for ensuring compliance with the Boren Amendment is a suit under 42 U.S.C. § 1983 brought by providers.

²³ Other pending challenges to egregious State Plans of which amici are aware of include, *inter alia*, *Albert Einstein Medical Center v. White*, Civ. No. 88-8831 (E.D. Pa. filed Nov. 17, 1988) (challenge to Pennsylvania 14.6% across-the-board reduction in aggregate group rates); *Michigan Hosp. Ass'n v. Department of Social Services*, No. L89-40070 CA (W.D. Mich. filed July 25, 1989) (challenge to prospective payments 9% less than actual operating costs and inadequate inflation update factors); *Ohio Hosp. Ass'n v. Dep't of Human Services*, No. 88-04961, slip op. (Oh. Ct. Claims. Nov. 2, 1988) (challenge to 6% and 8% per fiscal year reductions in outpatient reimbursement), *appeal pending*, No. 88-AP-1034 (Oh. Ct. App.).

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted,

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APPENDICES

APPENDIX A**Survey Of Procedures For Rate-Related Appeals By Medicaid Providers In The 50 States And The District Of Columbia**

In this Appendix, amici describe the rate-related Medicaid provider appeal procedures of the 50 States and the District of Columbia. Data for this survey were collected primarily pursuant to the Freedom of Information Act, 5 U.S.C. § 552 (1982 Supp. 1987), from files of HCFA's central headquarters in Baltimore, Maryland. Under Medicaid regulations, State Plans or amendments thereto are submitted in the first instance to the HCFA regional office with jurisdiction over the particular state. See generally 42 C.F.R. §§ 430.10-430.20 (1988). While some matters may be approved at the regional level, central office approval is required for the reimbursement portion of each State Plan. Health Care Financing Administration, Regional Office Manual (HCFA-Pub. 23-6), § 6301. Reimbursement methodology, including the appeals procedures required by 42 C.F.R. § 447.253(c), is contained for hospitals in Attachment 4.19-A, and for nursing homes in Attachment 4.19-D, to each State's Plan. When a Plan is ultimately approved, the State's original materials are returned to the regional office for filing. The central office retains a copy for its files. Because States may implement a new methodology concurrently with seeking HCFA approval, some of the State Plan versions actually in effect may be more current than those obtained from the central office for this survey. However, every Plan reviewed for this survey has been approved by HCFA, and so illustrates the kinds of appellate procedures that the agency deems sufficient to satisfy the requirements of the statute and regulations.

In a few states, the State Plan on file with the central office did not contain a procedure for provider rate appeals. In these states, amici AHA and AHCA contacted their State member organizations, or the State Medicaid

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agency, to obtain the necessary information. As the citations in this Appendix indicate, appeal procedures in these States may be located in State administrative regulations, or State Medicaid provider manuals.

ALABAMA

Hospital (Attachment 4.19-A, TN AL-88-17). Under the State Plan, providers of hospital services are permitted to appeal actions resulting from the provisions of the Plan. *Id.* at Sec. XIV, p. 11. However, providers are not permitted to use this appeals process to question the use of Medicaid standards and principles of reimbursement; the method of determining the trend factor; the use of all-inclusive prospective reimbursement rates; or the use of hospital group ceilings. *Id.*

Nursing Home (Attachment 4.19-D, TN AL-88-7). The only appeal procedure provided to nursing homes permits a contest of the Alabama Medicaid Agency's factual findings in support of its audit adjustments to the facility's cost report. *Id.* at 6.

ALASKA

Hospital (Attachment 4.19-A). A hospital which is aggrieved by an action of the Medicaid Rate Commission may appeal the decision and request an administrative hearing before a Hearing Officer appointed by the Governor. *Id.* at Sec. VII, pp. 7-8. The Plan specifies that judicial review is available if a facility feels aggrieved following the administrative hearing. *Id.*

Nursing Home (Attachment 4.19-D). The State Plan provides the same procedure as above for nursing homes. *Id.* at Sec. VII, pp. 11-12.

ARIZONA

Arizona does not participate in Medicaid, but rather in a HCFA demonstration project called the Arizona Health Care Cost Containment System ("AHCCCS"). Under this system, the exclusive means through which

providers may grieve against the Administration in connection with any adverse action, decision, or policy is to file a written grievance with the AHCCCS Appeal and Grievance Division within 35 days of the adverse action or decision. Ariz. Comp. Admin. R. & Regs. R9-22-804, p. 239 (5/30/89). No different time provision is indicated for challenges to policy, such as the State's rate-setting methodology, and compliance with the procedures is a prerequisite to judicial review. *Id.* at p. 241.a.

ARKANSAS

Hospital (Attachment 4.19-A, TN 88-26). Providers of hospital services are permitted to appeal their rates only for the following reasons: (1) costs of improvements incurred because of new certification or licensing requirements; (2) extraordinary circumstances (fires, floods, etc.); (3) program decisions of a substantive nature relating to application of the payment system; or (4) the rates are substantially below those paid during an earlier base period. *Id.* at Sec. 1.09, p. 15.

Nursing Home (Attachment 4.19-D). The Plan permits nursing homes to submit written appeals of any provisions of the State Medicaid Manual (Plan) or actions resulting therefrom, to the Commissioner of Arkansas Social Services. *Id.* Sec. 1-7. Appeals must be submitted within 30 days of notification of initial publication of a Manual provision, or an adjustment to a cost report. *Id.* No procedure exists for contesting Manual provisions after this time has elapsed.

CALIFORNIA

Hospital (Attachment 4.19-A, TN 87-16). The Plan permits a hospital to request an administrative adjustment to its interim rate. *Id.* at Sec. V, p. 9. However, the Plan specifically excludes consideration of the following:

- a. The use of Medicare standards and principles of retrospective reimbursement;

- b. The method for determining the input price index;
- c. The use of all-inclusive reimbursement rates;
- d. The use of a volume adjustment formula;
- e. The use of hospital peer groups;
- f. The use of percentile limits and the methods used to compute them.

An appeal of the Department's decision may be filed in accordance with the procedural requirements of Cal. Admin. Code, tit. 22, Div. 3, Ch. 3, Art. 1.5. *Id.* at 11. The appeal is limited to those items subject to an administrative adjustment listed above. *Id.*

Nursing Home (Attachment 4.19-D, TN 88-24). The Plan states that nursing homes will have the right to appeal audit findings which result in adjustments to program reimbursement or reimbursement rates. *Id.* at 4. However, the Plan specifically limits reimbursement rates to maximums set by the Plan itself, "[n]otwithstanding any other provisions" of the Plan. *Id.* at 1.

COLORADO

Hospital (Attachment 4.19-A). The Plan permits hospitals to appeal administratively only annual "add-ons" to the established base year rate. *Id.* at 1. Add-ons are increases in budgeted costs in excess of the consumer price index that can be justified on the basis of or resulting from a new or expanded service, a price increase, or a change in patient case mix. *Id.* Regulations applicable to all Medicaid providers limit appeals to a provider "adversely affected by a finding of fact or interpretation of rules. . . which results in a reduction in, or denial of, specific payments." 11 Colo. Code Regs. Sec. 8.0501 (effective 5/1/86).

Nursing Home (Attachment 4.19-D, TN 89-4). The Plan assures that Colorado has established procedures for nursing home rate determinations which permit pro-

viders to submit additional evidence and request prompt administrative review. *Id.* at 30. The regulations cited above for hospitals also apply.

CONNECTICUT

Hospital (Conn. Gen. Stat. § 17-311 (1989)). Connecticut hospitals may appeal any decision of the Commissioner of Income Maintenance in accordance with the aforementioned statute, which empowers the Commissioner to establish annual allowable costs for Medicaid Services. *Id.* An "aggrieved" hospital may request a rehearing as to any decision of the Commissioner. *Id.* at § 17-311(b). Items not resolved through the rehearing are submitted to an arbitration board consisting of one member appointed by the institution, one member appointed by the Commissioner, and one appointed by the chief court administrator. *Id.*

Nursing Home (Attachment 4.19-D, TN 88-58). A nursing home aggrieved by any decision of the Commissioner of Income Maintenance may file a written request to the Commissioner requesting a rehearing on the items of aggrievement. *Id.* at Sec. 17-311-104. If items of aggrievement are not resolved by the rehearing, the provider can file a request for binding arbitration, which must include a memorandum setting forth its position and contentions concerning the items of aggrievement. *Id.* at Sec. 17-311-107. The arbitration board consists of one member appointed by the provider, one member appointed by the Commissioner, and one member appointed by the chief court administrator from among the retired judges. *Id.* The Board may reverse the department if administrative findings, inferences, conclusions, or decisions are, among other things, violative of constitutional or statutory provisions. *Id.* at Sec. 17-311-112.

In contesting a rate decision, the provider may elect to pursue an administrative appeal in the Connecticut Superior Court in lieu of arbitration. *Id.* at Sec. 17-311-120.

DELAWARE

HCFA's copy of the State Plan contains no provision for provider rate appeal by hospitals or nursing homes. Appeals of "adverse actions" by the State Medicaid agency are permitted pursuant to State Medicaid regulations. Department of Social Services, Appeal Procedures of Adverse Actions for Providers (4/89). Requests for review must be mailed within 60 days of notice of adverse action. *Id.* at Sec. 5.

DISTRICT OF COLUMBIA

Hospital (Attachment 4.19-A, TN 88-6). The State Plan provides only an assurance of the existence of an appeal procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review of rates. *Id.* at Sec. 9, p. 4a. In a telephone conversation with the Comptroller's office, we were informed that, although there are no formal appeal procedures, hospitals are permitted to appeal informally adjustments to annual cost reports.

Nursing Home (Attachment 4.19-D). The Plan permits a nursing home to request a hearing before the Office of State Agency Affairs if the provider disagrees with a rate established by a Department of Human Services audit. *Id.* at Sec. VII.

FLORIDA

Hospital (Attachment 4.19-A, TN 88-19). The Plan permits a hospital the right to a hearing in response to adjustments to its cost report resulting from an audit. *Id.* at Sec. II (F), p. 8. The right to the hearing will be in accordance with Fla. Admin. Code Ann. r. 10-2.36, and with the Florida Administrative Procedure Act, Fla. Stat. Ann., Sec. 120.57.

Nursing Home (Attachment 4.19-D, TN 88-3). The same right to a hearing is available to nursing home providers in accordance with Fla. Admin. Code Ann. r. 10C-7.481(6), and with Fla. Stat. Ann., Sec. 120.57.

GEORGIA

Hospital (Attachment 4.19-A, TN 85-22). The State Plan provides a procedure whereby the hospital must submit a written request for review to the State Director of Hospital Reimbursement, with further appeal to the Director of Program Management. *Id.* at 10. If that decision is adverse to the hospital, a request for a hearing may be made in accordance with Chapter 500 of the Department's Policies and Procedures Manual. *Id.* at 12. This procedure may be used to consider only: (1) errors in cost report figures used to determine the base rate; (2) errors in calculation; (3) failure of the Department to comply with its stated policies; or (4) increased costs due to significant changes in patient care services. *Id.* at 10. See also Georgia Department of Medical Assistance Medicaid Manual, Chapter 500, Sec. 505.2.

Nursing Home (Georgia Department of Medical Assistance Medicaid Manual, Chapter 500). Georgia permits nursing homes to appeal the calculation of billing rates and related cost report disallowances. *Id.* at Sec. 504.3.

HAWAII

Hospital (Attachment 4.19-A, TN 88-30). The Plan permits a hospital to request reconsideration by the Department of its annual rate only "in extraordinary circumstances", or when there is a "[r]eduction in Medicaid average length of stay within a facility which produced a decrease in the average cost per discharge but an increase in the average cost per day." *Id.* at III-36. "Extraordinary circumstances" include acts of God, changes in life and safety code or licensure requirements, significant changes in case mix or new services occurring subsequent to the base year. *Id.* In addition, subsequent year adjustments to the facility's initial base year rate may not result in changes to the Plan's rate ceiling. *Id.* at III-35.

Nursing Home (Attachment 4.19-D, TN 86-17). The Plan permits nursing homes the right to request a rate

reconsideration only for additional capital costs, change in level of care provided, or "extraordinary circumstances," such as Acts of God, changes in life safety code requirements, or significant changes in patient mix. *Id.* at 11. Reconsideration may be appealed, but rates granted may not exceed the sum of component rate ceilings for the applicable facility classification specified in the Plan. *Id.* at 12.

IDAHO

Hospital (Attachment 4.19-A). The Plan permits hospitals to file grievances or complaints with the Bureau of Medical Assistance. *Id.* at 03.10500, p. 10. Adverse decisions may be appealed through the State Administrative Procedure Act, and judicial review is available. *Id.* The administrative appeal procedure is not available to contest, *inter alia*, the formula for determination of the Hospital Cost Index, or the principles of reimbursement which define allowable cost. *Id.* at 03.10463, p. 9.

Nursing Home (Attachment 4.19-D, TN 87-7). The Plan permits a nursing home to challenge an action or determination of the Department of Health and Welfare. *Id.* at Sec. 03.10305. The administrative process may be used only to adjust rates to correct inequitable application of a rule due to unforeseen cost increases (or decreases) not compensated for by the rule's inflation indices, which were outside the control of the provider. *Id.* at Sec. 03.10303. Challenges to the legal validity of a rule are excluded from the administrative process. *Id.* at Sec. 03.10304.02.

ILLINOIS

Hospital (Attachment 4.19-A, TN 82-9). The Plan permits a hospital to request review by the Department of Public Aid of its annual rate only for errors in calculation, severe cash flow problems (resulting from serving a disproportionate share of low income patients), or significant restructuring (to meet new health and safety

standards, to add or delete beds or a service category, or to make other capital changes resulting in stated cost increases). *Id.* at 4a-4c.

Nursing Home (Attachment 4.19-D, TN 86-44). The Plan provides for nursing homes to appeal, in writing, rate determinations. *Id.* at 35. If the appeal is submitted within 30 days of notification, it will (if upheld) be effective as of the beginning of the rate year. Later submitted appeals, if upheld, are effective the first day of the month following submission.

INDIANA

Hospital (Ind. Admin. Code tit. 470). Indiana regulations permit a hospital to provide additional information to the Department of Public Welfare should it disagree with its calculated rate. *Id.* at r. 5-11-1(f). The additional information must be based on actual financial data. *Id.* The Department will affirm or adjust the rate based on review of the additional information. *Id.* Further administrative and judicial review also are permitted. *Id.* at r. 5-4.1-27.

Nursing Home (Attachment 4.19-D, TN 83-5). The Plan permits a nursing home to request reconsideration of a rate determination, or any procedures in connection therewith, to the Medicaid Rate Setting Contractor. *Id.* at Sec. 27, p. 52. If the provider is dissatisfied with the decision of the Contractor, or other actions taken by the Department, an appeal is filed with the Department. *Id.* at 53. Further reviews are available before a hearing officer, the Board of Public Welfare, and finally in State court. *Id.* at 53-55. The Plan provides for correction on appeal only if the rate established by the Contractor's action was not in accordance with the ratesetting criteria in the Plan. *Id.* at 53.

IOWA

Hospital (Attachment 4.19-A, TN MS-87-27). The plan permits a hospital provider to file a written appeal

with the Department of Human Services if dissatisfied with a rate determination. *Id.* at Sec. 20, p. 12. Hearings are conducted by the Department of Inspections and Appeals. *Id.* The Department of Human Services makes a decision based on the recommendation of the Department of Inspections and Appeals. *Id.*

Nursing Home (Attachment 4.19-D). If dissatisfied with the determination of its base year allowable cost, a nursing home may file an appeal and request for reconsideration with the Chief of the Bureau of Medical Services. *Id.* at Sec. 11, p. 3. In addition, Iowa regulations permit the Department to consolidate the claims of several providers where the sole issue involved is one of state or federal law or policy. Iowa Admin. Code. r. 441-7.5 (1987).

KANSAS

Hospital (Attachment 4.19-A, TN MS 88-27). A hospital may obtain administrative review only upon evidence of at least a 10% variation between its current Medicaid cost and its per diem rate. *Id.* at Sec. N, p. 7. The Commissioner of Income Maintenance shall render a decision which is appealable under Kan. Admin. Regs., Sec. 30-7. *Id.* There is no provision to contest rates (or rate methodology, if permitted) unless the 10% criterion is met.

Nursing Home (Attachment 4.19-D, TN MS-89-15). The Plan for nursing homes provides a procedure for individual providers to obtain an "exception" to their assigned rates by submitting additional evidence demonstrating that the provider is efficiently and economically operated, but is being adversely affected by the Plan payment rates. *Id.* at p. 20A.

KENTUCKY

Hospital (Attachment 4.19-A, TN 86-4). A hospital may appeal a program decision only in the following circumstances: (1) addition of new and necessary services

requiring certificate of need approval; (2) major changes in case mix or types/intensity of services; (3) costs of improvements required by new licensing or certification requirements; (4) extraordinary circumstances (floods, etc.); substantive program decisions relating to application of the payment system. *Id.* at Sec. 110, p. 110.01.

Nursing Home (Kentucky Medical Assistance Program Reimbursement Manual, TN 84-16). Nursing homes are permitted administrative review of program decisions relating to the application of the policies and procedures governing the nursing home payment system. *Id.* at Sec. 119, p. 119-01.

LOUISIANA

Hospital (Attachment 4.19-A, TN 84-9). The Plan provides that hospitals may appeal their rates to the DHHR Appeals section. *Id.* at Sec. III, p. 11. An informal conference is first scheduled between the hospital and the state agency to discuss the issues of the appeal. *Id.* If the informal discussion does not resolve these issues, the hospital may request an administrative hearing with the DHHR Appeals Section. *Id.* at p. 12. The DHHR Appeals Section makes a recommendation to the Secretary. The department then makes a final decision, subject only to judicial review by the courts as provided in the State Administrative Procedure Act, La. Rev. Stat. Ann., Sec. 49:951. *Id.* at 13.

Nursing Home (Attachment 4.19-D (1)). The Plan for nursing homes assures that the State provides an appeals procedure that permits individual providers to submit additional evidence and receive prompt administrative review. *Id.* at p. 4. In a telephone conversation with the Department of Health and Human Resources, however, we were informed that a provider could not appeal a rate determination.

MAINE

Hospital (Attachment 4.19-A, TN 88-07). The Plan assures that a provider appeals system is in place which allows individual providers an opportunity to submit ad-

ditional evidence and request prompt administrative review of payment rates. *Id.* at 2.

Nursing Home (Attachment 4.19-D, TN 88-14). Nursing homes may appeal audit adjustments to the Maine Department of Human Services. On appeal, the validity of a rate is judged "solely on the basis of its conformity with the principles governing the determination of rates contained in this attachment [4.19-D]." *Id.* at 18.

MARYLAND

Hospital (Md. Regs. Code tit. 10, Sec. 37.10 (1988)). A hospital may request a temporary change in rates at any time if it has experienced a decline in net revenue or an increase in expenses due to factors beyond its control. *Id.* at Sec. 10.37.10.05.

Maryland also permits a hospital to file an application with the Health Services Cost Review Commission to request an alternative method for submitting or reviewing its rates and charges. 10.37.10.06(A). The Executive Director may grant a temporary approval of an alternative method of rate determination. 10.37.10.06 (B).

Nursing Home (Medical Care Programs ICF Services). Maryland permits nursing homes to appeal only audit findings. *Id.* at pp. 608-45.

MASSACHUSETTS

Hospital (Attachment 4.19-A(2), TN 88-12). HCFA retains two Massachusetts hospital plans, one for acute care facilities, one for non-acute facilities.

The Plan does not contain an appeal procedure for acute care hospitals. In a telephone conversation with the State Rate Setting Commission, we were informed that acute care hospitals may appeal Medicaid reimbursement rates in accordance with State regulations. Mass. Regs. Code tit. 801, Sec. 1.03 (1986). Appeals from actions or inactions on the part of the Rate Setting Com-

mission are permitted for the appeal of interim and final rates. *Id.* at Sec. 1.03(12)(c), (d).

The Plan for nonacute hospitals provides for appeal to the Division of Administrative Law Appeals, pursuant to the requirements of Mass. Gen. L. Ch. 6A, Sec. 36 and Mass. Gen. L. Ch. 7, Sec. 4H, in two circumstances. First, a hospital may request an increase in its allowed costs due to costs beyond its control. *Id.* at 10. Such requests will be granted only if the additional costs: (1) are due to correcting deficiencies related to hospital licensure or participation in Medicare or Medicaid; (2) are generated by compliance with new, non-discretionary regulations mandating expenses; (3) result from disaster losses in excess of (or not covered by) insurance; (4) are allowed in connection with a major capital expenditure or substantial change in services requiring a certificate of need; (5) result from a new service; (6) result from certain wage adjustments which are demonstrated to be cost-effective; (7) result from an increase in patient care costs due to serving a more intensely ill patient population. *Id.* at 10-11. Second, a hospital may request an adjustment if there has been an arithmetic error. *Id.* at 20.

Nursing Home (Mass. Regs. Code tit. 114.2, Sec. 2.20 (1987)). Massachusetts reimburses certain nursing homes through interim rates with retrospective adjustments, and certain nursing homes through prospective rates. This regulation permits both kinds of providers to petition for an increase to their rates. *Id.* at Sec. 2.20, 2.21, 5.15. Petitions for increase in interim rates are granted only for facilities with a population of more than 75 percent Medicaid patients, and only to implement certain statutory wage increases for nurses and nurse aides. *Id.* at Sec. 2.20, 2.21. As to prospective rates, a provider aggrieved by a rate of payment may file an appeal, the validity of which will be "judged solely on the basis of its conformity with the principles governing the determi-

nation of rates contained in" the ratesetting methodology set in the regulations. *Id.* at Sec. 5.16(1) and (2).

MICHIGAN

Hospital (Attachment 4.19-A, TN 88-6). The Plan permits a hospital to appeal its rate of payment as well as the components used to determine the rate. *Id.* at Sec. IV, p. 18. Appeal is restricted to the extent that incorrect data were used in calculation, except that the appeal panel or ALJ may also hear appeals of "other items deemed . . . to be within the scope of their jurisdiction." *Id.* An order from the Director of the Department of Social Services states that ALJs do not have "authority to make decisions on constitutional grounds, overrule statutes, overrule promulgated regulations or overrule or make exceptions to the Department policy set out in the program manuals." Amended Delegation of Hearing Authority (April 1, 1981). ALJs are permitted to make a recommendation to the Director of the Bureau of Administrative Hearings when they believe Department policy to be out of conformity with case law, statute, or promulgated regulation, but there is no provision to permit a party to appeal an ALJ's decision on this issue. *Id.*

Nursing Home (Attachment, 4.19-D, TN 87-9). The Plan provides for an informal or formal review of an adverse action, which requires a nursing home to submit an application for relief to the state agency within 45 days of notification. *Id.* at Sec. VIII, p. 1. However, no administrative review is permitted for elements of the program that would necessitate a change for all providers, including the "principles of reimbursement and guidelines which define allowable costs." *Id.* The same Delegation of Authority cited above for hospitals also applies.

MINNESOTA

Hospital (Attachment 4.19-A, TN 88-69). "Rate Appeals" are taken in the first instance to the reimburse-

ment staff of the Department of Human Resources. *Id.* at 9. Appeals that are not settled by reimbursement staff are made to a five member appeals board, appointed by the Commissioner of Human Resources, which makes recommendations to the Commissioner. *Id.* Hospitals may appeal "a decision of the Commissioner" through Minnesota statutes (presumably the Administrative Procedure Act). *Id.*

Nursing Home (Attachment 4.19-D; Minn. R. 256B.50). A nursing home may appeal from determination of a payment rate. *Id.* at Subd.1c, p. 5501. Nursing homes may challenge the validity of the Commissioner's rules in the court of appeals if it appears that the rule or its threatened application impairs or threatens to impair the petitioner's legal rights. Minn. Stat. Ann., Sec. 14.44.

MISSISSIPPI

Hospital (Attachment 4.19-A, TN 81-1). The Plan permits a hospital to appeal its rate to the Mississippi Medicaid Commission. *Id.* at Sec. IV, p. 8. Appeals are limited to new costs resulting from major changes in case mix, the addition of new and necessary services, use of incorrect data or calculation error, extraordinary circumstances (riot, strike, flood, etc.). *Id.*

Nursing Home (Attachment 4.19-D, TN 88-1). The plan permits a nursing home to submit a written request for a formal hearing in response to a rate notice. *Id.* at 19. The appeal must be accompanied by a statement and documents setting forth the facts which the provider contends place it in compliance with the Commission's regulations. *Id.* In addition, the Mississippi Medicaid Manual states that appeals of matters relating to payment rates or reimbursement may be considered only if not otherwise previously considered by the Division of

Medicaid under Public Hearing Procedures. Long Term Care Manual (July 1, 1989) at p. I-7.

MISSOURI

Hospital (Attachment 4.19-A, TN 88-3/87-01). The Plan permits a hospital to request an informal review of actions resulting from the provisions of the Plan. *Id.* at Sec. V(E), p. 10. Items which will not be subject to review include: the use of Medicare standards and reimbursement principles; the method for determining the trend factor; the use of all-inclusive prospective reimbursement rates; and increased cost resulting from change of ownership. *Id.* at 12. In addition, the Missouri Supreme Court has held that State administrative agencies have no authority to render declaratory rulings regarding the validity of agency rules. *State Tax Commission v. Administrative Hearing Commission*, 641 S.W. 2d 69, 75 (Mo. banc 1982). See Mo. Code Regs. tit. 13, Sec. 70-10.010 (8/89) (ratesetting methodology as agency rule).

Nursing Home (Attachment 4.19-D, TN 88-22). The Plan permits a nursing home to obtain reconsideration of its rate by an advisory committee only for costs related to changes in the facility's case mix, or costs resulting from other extraordinary circumstances. *Id.* at 51. The Plan prohibits administrative review of the trend factor, the use of prospective rates, or the provider's initial cost base. *Id.* The hospital limitation cited above also applies.

MONTANA

Hospital (Mont. Admin. Rules, Sec. 46.12.506-.510). Hospitals have the opportunity for a fair hearing, in accordance with the procedures set forth in Mont. Admin. R. 46.2.202, only to contest the computation of their interim payment rates (or final settlements for capital and medical education costs), coding errors resulting in incorrect DRG assignment and determination of medical

necessity, outlier status, and readmission/transfer decisions. *Id.* at R. 46.12.510.

Nursing Home (Attachment 4.19-D, TN 88(10)19). A nursing home may request an administrative review of the Department of Social and Rehabilitative Services' written findings, recommendations, or rate. *Id.* at Sec. 46.12.1210, p. 23. If the decision of the review is adverse to the provider, an appeal for a fair hearing can be made to the Department. *Id.* The hearing officer will render a proposed decision, and the provider is permitted a further appeal by filing a notice of appeal with the hearing officer to be forwarded to the Department Director. *Id.* at 23. Judicial review of the decision of the Department Director is permitted under the State Administrative Procedure Act, Title 2, chapter 4, part 7, Mont. Code Ann. *Id.*

NEBRASKA

Hospital (Attachment 4.19-A, TN MS-89-6). The Plan assures that a hospital may submit additional evidence and request prompt administrative review of its prospective rate. *Id.* at 8a. The hospital is also permitted to utilize this procedure to appeal an adjustment to its rate.

Nursing Home (Attachment 4.19-D, TN MS-84-3). The Plan permits a nursing home to request an administrative appeal of a final decision or inaction in the process for determining the facility's allowable cost. *Id.* at Sec. 12-011.13, p. 26.

NEVADA

Hospital (Nevada State Welfare Division, Medicaid Services Manual, MTL 8/89). A hospital is permitted to appeal its rate. *Id.* at Sec. 206.2. The appeal must include the specific rate adjustment requested with supporting documentation and documentation of adverse financial impact. *Id.* In a telephone conversation with the

Welfare Division of the Department of Human Resources, we were informed that this procedure may not be used to appeal the ratesetting methodology.

Nursing Home (Nevada SNF & ICF Medicaid Manual). Nevada permits providers to appeal audit adjustment settlements. *Id.* at Sec. 506.2.

NEW HAMPSHIRE

Hospital. The Plan contains no provision for appeals by hospitals. In a telephone conversation with the State Medicaid Director, we were informed that because hospitals are reimbursed on a diagnosis-related group ("DRG") basis, there are no appeal procedures in place.

Nursing Home (Attachment 4.19-D, TN 87-10). The Plan provides a procedure for individual nursing homes to appeal unresolved disputes that may arise concerning application of the principles of reimbursement defined in the Plan. *Id.* at Sec. 9999.11, p. 38.

NEW JERSEY

Hospital (1983 Standard Hospital Accounting and Rate Evaluation Rate Review Guidelines). Hospitals may file appeals of their payment rates with Health Economics Services, Department of the Public Advocate. *Id.* at G-17. The purpose of the appeal is "to determine if the Guidelines were properly interpreted and executed." *Id.* at G-3. The Plan also provides a provision which permits hospitals faced with unpredictable and uncontrollable changes in costs to submit a request for adjustment to the Commissioner. *Id.* at G-18.

Nursing Home (Attachment 4.19-D, TN 86-1). The Plan provides a two level appeal process for nursing homes that believe that, "owing to an unusual situation, the application of these guidelines results in an inequity." *Id.* at Sec. 3.20, p. C-36. A Level I appeal is heard by representatives from the Department of Health ("DOH") and the Department of Human Services ("DHS"). The

recommended solution will ultimately be forwarded to the Director, Division of Medical Assistance and Health Services for approval. This level is limited to matters peculiar to individual providers.

If the provider is not satisfied with the results of the level I appeal, it may request a hearing before an Administrative Law Judge (Level II). At Level II, the burden is on the provider to establish its entitlement to benefits under the State's Cost Accounting and Rate Evaluation System Guidelines (the State's ratesetting methodology). *Id.* at C-38.

NEW MEXICO

Hospital (Attachment 4.19-A, TN 89-01). A hospital may appeal its rate and its application only if circumstances beyond the hospital's control have caused rates to fall at least 5% below actual allowable costs. *Id.* at Sec. II, p. 2.

Nursing Home (Attachment 4.19-D, Part 1, TN 88-6). The Plan permits a nursing home to file a request for reconsideration of the base year rate determination (or final settlement in the case of a change in ownership). *Id.* at Sec. IX, p. 17. The Medical Assistance Division Director delivers the request and his response to the Secretary of the Department of Human Services, who is empowered (but not required) to hold a hearing. The Secretary's final determination "shall be made in accordance with applicable provisions of the Plan." *Id.* at 18.

NEW YORK

Hospital (Attachment 4.19-A(I), TN 85-34). The appeal procedure provided in the State Plan permits a hospital to appeal audit adjustments to its cost report, as to those items of the audit report that present a factual issue. *Id.* at 10. Pursuant to State Medicaid regulations, the State Commissioner of Health may consider rate revisions only for the following reasons:

- (1) mathematical or clerical errors in the rate calculation process, or in the development of [peer] groups;
- (2) mathematical or clerical errors in data submitted by the facility;
- (3) increases in the operating costs of a facility resulting from additional or expanded programs, staff or services mandated for the facility by the Commissioner;
- (4) increases in the operating expenses of a facility resulting from capital renovations, expansion, replacement or inclusion of programs, staff or services approved by the Commissioner through a certificate of need process;
- (5) requests for relief for intensity appeals, atypical costs, length of stay penalties, specialty hospital and physicians' base to base noncomparability of cost data, nonprojectable capital, waiver of unfunded depreciation, return on investments of proprietary hospitals, and adjustment in target volume;
- (6) the reduction of costs related to the elimination of hospital inpatient service;
- (7) requests for relief from the ceiling provisions
- (8) requests for waivers of minimum utilization standards; and
- (9) requests for reimbursement of costs which were not included in the base year upon which the rate was established.

N.Y. Comp. Code R. Regs. tit. 10, Sec. 86-1.17(a)(1)-(9). The decision of the Commissioner is final unless a hearing is requested with a rate review officer. *Id.* at Sec. 86-1.17(b). The rate review officer may grant or deny the request for a hearing. *Id.* at Sec. 86-1.17(c)(2). The rate review officer shall make a recommenda-

tion to the Commissioner of Health for final approval or disapproval. *Id.* at Sec. 86.1-17(c)(3).

Nursing Home (Attachment 4.19-D, Part I, TN 86-4). The Plan permits a nursing home to appeal rate determinations only for increased costs resulting from utilization above 90 percent of bed capacity for a period of six months, errors in the cost and/or statistical data, significant new required or approved cost increases, or other changed circumstances. *Id.* at Sec. 86-2.14, p. 53.

NORTH CAROLINA

Hospital (Attachment 4.19-A, TN 88-17). Hospitals may request reconsideration of rate determinations by the Division of Medical Assistance. *Id.* at 2. Operating (as opposed to capital) rate appeals are considered only on the basis of additional cost of essential new services or changes in case mix, and even an adjusted rate cannot exceed the rate limits set by the Plan itself. *Id.*

Nursing Home (Attachment 4.19-D, TN 88-15). The Plan permits a nursing home to appeal rate determinations in accordance with the procedures set forth in N.C. Admin. Code Tit. 10, r. 26J.0200. (now r. 26K.000). *Id.* at .0106, p. 15. A rate may be adjusted on appeal only if the provider can demonstrate that an adjustment is necessary to protect the health and safety of its patients and to sustain its financial viability. *Id.* The adjusted rate may not exceed the maximum rate established in the Plan itself. *Id.*

NORTH DAKOTA

Hospital (Attachment 4.19-A, TN 87-13). The Plan merely assures that appeal procedures for hospital providers are in place and remain unchanged. In a telephone conversation with the State Medical Services Division, we were informed that there are no formal procedures in place for hospitals to appeal rate determinations.

Nursing Home (Attachment 4.19-D, TN 87-10). The Plan provides that a nursing home may appeal a rate determination to the Referee Supervisor, Department of Human Services. *Id.* at Sec. 75-02-06-17. Appeals are limited to those including a computation and the dollar amount which reflects the party's claim as to the correct computation and dollar amount for each disputed item. *Id.*

OHIO

Hospital (Attachment 4.19-A, TN 87-13). The Plan specifically excludes from the appeals process review of the methodology used to determine rates. Ohio Admin. Code, Sec. 5101:3-2-0712(E), p. 11.

Nursing Home (Attachment 4.19-D, TN 80-16). The appeal procedures in the Plan permit nursing homes an opportunity for a hearing under Chapter 119 of the Revised Code (Administrative Procedures Act) to contest a final fiscal audit. Ohio Admin. Code, Sec. 5101:3-1-57. Administrative action not subject to hearings under Chapter 119 may be reconsidered by the appropriate division chief upon written request by the provider to the Director of the Ohio Department of Public Welfare. *Id.*

OKLAHOMA

Hospital (Attachment 4.19-A, TN 86-17). The Plan provides an assurance that providers of hospital services may submit a request for rate review to the Director of the Department of Human Services for consideration and a final decision. *Id.* at p. 2. The Plan also indicates that providers are allowed an opportunity to submit additional evidence and a prompt administrative review regarding the appropriateness of the payment rate will be conducted. *Id.*

Nursing Home (Medical Services Provider Manual). Oklahoma permits nursing homes to request review of nursing home payment rates to the Director of the Department of Human Services. *Id.* at Ch. 1, p. 12. The

State also provides that facilities are allowed to submit additional evidence and receive prompt review of the appropriateness of the rate. *Id.*

OREGON

Hospital (Attachment 4.19-A, TN 88-17). Under the Plan, hospitals may request an appeal or exception to any State decision affecting payment rates pursuant to Or. Admin. R. 461-13-191 through 461-13-225. *Id.* at 13. These regulations, which apply to hospitals and nursing homes, limit reconsiderations to: (1) individual institutional provider payment ratesetting; (2) issues related to prepaid capitated contracts; or (3) any other issues deemed appropriate by the agency. Or. Admin. R. 461-13-191(2). As the only specific provision relating to rate-setting, the first clause should preclude the more general language of the third clause from authorizing broad-based appeals.

Nursing Home (Attachment 4.19-D, Part 1, TN 87-34). The Plan states that a nursing home may appeal interim rates or year end settlements to the Senior Services Division. *Id.* at Sec. VI, p. 6. The hospital regulations described above also apply.

PENNSYLVANIA

The State Plan contains no provision for appeals by hospitals or nursing homes. Pennsylvania's administrative regulations furnish providers a fair hearing process for certain medical assistance decisions. 55 Pa. Code § 275.1(a), p. 275-1 (May, 1989). The regulations specifically preclude administrative hearing officers from rendering a decision on the validity of a Departmental regulation, and from invalidating or modifying a regulation. *Id.* at Sec. 275.4(h), p. 275-21.

RHODE ISLAND

Hospital (Attachment 4.19-A). The Plan provides a statewide "maxicap" on hospital operating expenses. *Id.*

at 31. This amount is negotiated annually by representatives of the State and participating hospitals prior to commencement of the new rate year. While individual hospital budgets may be adjusted (through mediation or arbitration between a provider and the State), *see id.* at 46-50, the aggregate total of all hospital expenses in the state may not exceed this ceiling. *Id.* at 31.

Nursing Home (Principles of Reimbursement for Skilled Nursing and Intermediate Care facilities, TN 88-01). The Plan permits a nursing home to request a review of computation of the facility's assigned rate if the provider is not in agreement with the base year or with application of the State's Principles of Reimbursement for the applicable calendar years. *Id.* at 16.

SOUTH CAROLINA

Hospital (Attachment 4.19-A, TN 87-10). Hospitals may have their rates reconsidered only if one of the following has occurred since the base year: (1) change in case mix; (2) error in calculation; (3) extraordinary circumstances. *Id.* at 25-26. The Plan specifically prohibits reconsideration (appeal) of the State's rate methodology. *Id.* at 26.

Nursing Home (Attachment 4.19-D, TN 87-14). The Plan permits nursing homes to appeal only a final audit determination in connection with a desk review of the provider's cost report. *Id.* at 8.

SOUTH DAKOTA

Hospital (Attachment 4.19-A, TN 88-12). The Plan assures that the State Department of Social Services has administrative review procedures to meet the need for provider appeals required by 42 C.F.R. § 447.258 [sic]. *Id.* at 4.

Nursing Home (S.D. Admin. R. 67:16:04:07.02 (1989)). South Dakota regulations permit a facility to

appeal only a disallowed expenditure or adjustment based on a Department audit of its cost report. *Id.*

TENNESSEE

Hospital (Attachment 4.19-A, TN 88-15). The Plan lacks a specific appeal procedure, but adjustments to a facility's rate are permitted only for errors in computation, additional capital expenditures pursuant to a certificate of need, or significant changes in case mix. *Id.* at p. 10.

Nursing Home. Tennessee's State Plan contains no provision for rate appeals by nursing home providers. The State has no published procedures, but permits appeal of specific rates informally through the Comptroller of the Treasury, and formally through the State Administrative Procedures Act.

TEXAS

Hospital (Attachment 4.19-A, TN 89-20). Hospitals are permitted to appeal individual claims (as specified in the State Plan), mechanical, mathematical, and data entry error in base year claims data, and incorrectly computed subsequent adjustments to the hospital's base year claims data. *Id.* at 5-7. The Plan expressly precludes appeal of the prospective payment methodology used by the State. *Id.* at 7.

Nursing Home (Attachment 4.19-D, 85-2). The Plan assures that an appeals procedure for nursing home providers is available to contest any cost report disallowance. *Id.* at 2.

UTAH

Hospital (Attachment 4.19-A, TN 89-11). The Plan assures that the State has administrative review procedures to handle provider appeals as required by 42 C.F.R. § 447.253(c). *Id.* at Sec. 193.

Nursing Home (Attachment 4.19-D, TN 88-28). The Plan states that a nursing home may appeal an audit

settlement or a revised payment rate. *Id.* at Sec. 920, p. 14. An appeal must identify a specific audit adjustment or rate calculation. *Id.* The purpose of the appeal procedure is to allow individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates. *Id.* at 930.

VERMONT

Hospital (Attachment 4.19-A). The Plan merely assures that appeals of the rates set are allowed.

Nursing Home (Attachment 4.19-D, TN 88-11). The Plan permits a nursing home to submit an appeal to the Division of Rate Setting. Appeals are limited to errors in the calculation of prospective rates. *Id.* Sec. 209. A party aggrieved by a final order of the Division has the option of appeal to the Vermont Supreme Court, trial *de novo* in superior court, or a hearing conducted by an accountant appointed by the Secretary of Human Services. Vt. Stat. Ann. tit. 33, Sec. 195.

VIRGINIA

Hospital (Attachment 4.19-A). The Plan specifically prohibits appeal of the use of Medicaid principles of reimbursement to determine reimbursement of costs (other than operating costs for inpatient care), the calculation of the initial group ceilings on allowable operating costs for inpatient care, and the use of the Consumer Price Index as a prospective rate escalator. J.A. 33.

Nursing Home (Attachment 4.19-D, TN 86-11). Nursing homes may appeal the interpretation and application of the Plan's principles of reimbursement. *Id.* at Sec. 3.3, p. 33. The Plan specifically prohibits appeal of the principles of reimbursement themselves. *Id.* at Sec. 3.1, p. 32.

WASHINGTON

Hospital (Division of Medical Assistance, Inpatient Hospital Rate Appeal, effective April 1, 1986). Washington permits hospitals to appeal their rates by submitting a written notice, including a statement of the issue being appealed and the requested re-calculation of the rate. *Id.* at 1. The procedure allows appeals of computation errors, errors in cost report data, or changes in case-mix or cost apportionment. *Id.*

Nursing Home (Attachment 4.19-D, TN 87-18). The Plan permits a nursing home to request a revision of its rate at any time. *Id.* at Sec. IV, p. 5. The provider may appeal first through an administrative review conference. *Id.* If the decision at the administrative review conference is adverse to the provider, a request for a fair hearing may be made in accordance with the Administrative Procedure Act, Wash. Rev. Code, Sec. 34.04. *Id.*

WEST VIRGINIA

Hospital (Department of Human Services, Medicaid Program Regulations, Chapter 700). State Medicaid Program regulations (applicable to all Medicaid providers) permit a provider to obtain administrative review through an "informal conference," during which the provider may present its case, provide additional information bearing on administrative action, or receive clarification or explanation of relevant policy. *Id.* at Sec. 764, p. 5. If dissatisfied, the provider may proceed to a formal hearing where the findings of fact and conclusions of law arrived at below may be challenged. *Id.* at Sec. 765.1, p. 6. Judicial review of this decision is available. *Id.* at Sec. 765.3, p. 6.

Nursing Home (Attachment 4.19-D, TN 86-7). The Plan contains only an assurance that there is an appeals or exceptions procedure for review of payment rates that allows individual providers to submit additional information and receive prompt administrative review. *Id.* at 7.

The Medicaid regulations described above also apply to nursing homes.

WISCONSIN

Hospital (Attachment 4.19-A) The Plan assures that the State provides an appeal mechanism that allows providers the opportunity to submit additional evidence and to request prompt administrative review of payment rates. *Id.* at 1. A hospital may seek a rate adjustment only for inappropriate calculation of rates (including clerical errors) or significant change in patient mix to include more low-income patients. *Id.* at 16. The Plan defines "inappropriate calculation of rates" to mean the application of the ratesetting methods to incomplete or incorrect data. *Id.*

Nursing Home (Attachment 4.19-D, TN 89-0011). The Plan provides that a Nursing Home Appeals Board is available for redress in the event that a facility has extraordinary fiscal circumstances. *Id.* at Sec. 1.400. Providers also are permitted to appeal a final ratesetting action. *Id.* at Sec. 1.700. The Plan further provides that a nursing home may request an administrative review of cost-finding decisions. *Id.* at Sec. 1.800.

WYOMING

HCFA's copies of the Plan contain no provision for rate-related appeals by hospitals or nursing homes. The State's Rules for Medicaid Administrative Hearings are separately printed, and apply to all Medicaid providers. Providers may appeal "adverse actions." *Id.* at Sec. 4(a), p. 1. The rules specifically state that the term adverse action "does not include an appeal of ratesetting methodology." *Id.*

APPENDIX B

Classification of Procedures for Rate-Related Appeals By Medicaid Providers

In this Appendix, *amici* classify the procedures for rate-related appeals by Medicaid providers (hospitals and nursing homes) according to a number of relevant categories. States in which the procedure contains limitations fitting more than one category are listed only once, and the States in which we were unable to locate a procedure (hospital: New Hampshire, North Dakota) are not included. More detailed information on the rules of each jurisdiction and citations to these rules are furnished in Appendix A.

B-2

I. States In Which Appeals Are Limited To Correction Of Errors Or Changed Circumstances

<u>Limitation</u>	<u>States</u>	<u>Total</u>
		Nursing Hospital Home
A. Audit adjustments to or factual findings in cost reports, errors in calculation or computation		
1. Hospital	Florida, Illinois*, Indiana, Massachusetts*, Mississippi*, Montana, New York*, Tennessee*, Washington*, Wisconsin*	10
2. Nursing Home	Alabama, Florida, Maryland, Nebraska, Nevada, New York*, South Carolina, South Dakota, Texas, Vermont, Wisconsin*	11
B. Changed circumstances (patient case-mix, new services or capital expenditures, extraordinary circumstances) since base year		
1. Hospital	Arkansas, Colorado, Kansas, Kentucky, Maryland, New Mexico	6
2. Nursing Home	Kansas	—
TOTALS		16 12

* Indicates procedure permits appeals under both A and B.

B-3

II. States In Which Appeals Of Rate Methodology Specifically Prohibited

<u>Limitation</u>	<u>States</u>	<u>Total</u>
		Nursing Hospital Home
A. No appeal of principles of reimbursement or rate methodology		
1. Hospital	Alabama, Idaho, Michigan, Ohio, Pennsylvania, South Carolina, Texas, Wyoming	8
2. Nursing Home	Idaho, Michigan, Pennsylvania, Virginia, Wyoming	5
B. No appeal of key elements of rate methodology (e.g., inflation factor or rate ceilings)		
1. Hospital	California, Hawaii, Missouri, North Carolina, Rhode Island, Virginia	6
2. Nursing Home	California, Hawaii, Missouri, North Carolina	4
C. Appeals limited to determining conformity of rate with established methodology		
1. Hospital	New Jersey, Georgia	2
2. Nursing Home	Indiana, Maine, Massachusetts, Mississippi, New Jersey, New Mexico	6
D. Appeals limited to contests to application or interpretation of established methodology		
1. Nursing Home	Colorado, New Hampshire, Kentucky, Rhode Island	4
TOTALS		16 19

III. States In Which Particular Limitations Preclude Challenges To Ratesetting Methodology

<u>Limitation</u>	<u>States</u>	<u>Total</u>
		Nursing Hospital Home
A. Appeals must be brought within specified time of adverse action		
1. Nursing Home	Arkansas	1
B. Appeals must identify particular computations and adjustments contested		
1. Hospital	Nevada	1
2. Nursing Home	North Dakota, Utah	— 1
TOTALS		2 3

IV. States In Which Procedures Limited To Appeal Of Rates Or Rate Determinations

<u>Limitation</u>	<u>States</u>	<u>Total</u>
		Nursing Hospital Home
A. Provider permitted to present new evidence and receive review of payment rates		
1. Hospital	District of Columbia, Maine, Nebraska, Oklahoma, South Dakota, Utah	6
2. Nursing Home	Louisiana, West Virginia	2
B. Provider permitted to appeal rate or rate determination		
1. Hospital	Iowa, Louisiana, Oregon, Vermont	4
2. Nursing Home	District of Columbia, Georgia, Illinois, Montana, Oklahoma, Oregon, Tennessee, Washington	8
TOTALS		10 10

V. States In Which Appeal Of Rate Methodology May Be Permitted By Rule

<u>Rule</u>	<u>States</u>	<u>Total</u>
		Nursing Hospital Home
A. Provider may appeal action or decision of rate commission		
1. Hospital	Alaska, Arizona, Connecticut, Delaware, Minnesota	5
2. Nursing Home	Alaska, Arizona, Connecticut, Delaware	4
B. Provider may appeal validity or legality of rule		
1. Hospital	West Virginia	1
2. Nursing Home	Iowa, Minnesota	2
C. Provider may appeal administrative action not otherwise provided for by letter		
1. Nursing Home	Ohio	—
TOTALS		6 — 1
		— 6 7

APPENDIX C

List of Reported Federal Cases in Which Violations of The Boren Amendment Have Been Alleged¹

- AMISUB (PSL) v. Colorado Dept. of Social Services*, 879 F.2d 789 (10th Cir. 1989), petition for cert. filed, 58 U.S.L.W. 3322 (U.S. Oct. 25, 1989) (No. 89-682);
- Hoodkroft Convalescent Center Inc. v. New Hampshire Division of Human Services*, 879 F.2d 968 (1st Cir. 1989);
- West Virginia Univ. Hosps. Inc. v. Casey*, 885 F.2d 11 (3d Cir. 1989);
- Colorado Health Care Ass'n v. Colorado Dep't of Social Services*, 842 F.2d 1158 (10th Cir. 1988);
- Wisconsin Ass'n v. Revitz*, 820 F.2d 863 (7th Cir. 1987);
- Wilmac Corp. v. Bowen*, 811 F.2d 809 (3d Cir. 1987);
- Coos Bay Care Center v. Oregon Dep't of Human Resources*, 803 F.2d 1060 (9th Cir. 1986), cert. granted, 481 U.S. 1036, vacated as moot, 484 U.S. 806 (1987);
- Nebraska Health Care Ass'n v. Dunning*, 778 F.2d 1291 (8th Cir. 1985), cert. denied, 479 U.S. 1063 (1987);
- United Hosp. Center, Inc. v. Richardson*, 757 F.2d 1445 (4th Cir. 1985);
- Hillhaven Corp. v. Wisconsin Dep't of Health and Social Services*, 733 F.2d 1224 (7th Cir. 1984);
- Oberlander v. Perales*, 740 F.2d 116 (2d Cir. 1984);
- Alabama Hosp. Ass'n v. Beasley*, 702 F.2d 955 (11th Cir. 1983);
- Mississippi Hosp. Ass'n, Inc. v. Heckler*, 701 F.2d 511 (5th Cir. 1983);

¹ Based on a search of West's Federal Reporters, the Medicare & Medicaid Guide (CCH), WESTLAW, and LEXIS.

Hadley Memorial Hosp. Inc. v. Schweiker, 689 F.2d 905 (10th Cir. 1982);

Washington State Health Facility Ass'n v. Washington Dep't of Social and Health Services, 698 F.2d 964 (9th Cir. 1982);

Charleston Memorial Hosp. v. Conrad, 693 F.2d 324 (4th Cir. 1982);

Chicago Osteopathic Medical Centers v. Duffy, No. 88-C-1174 (N.D. Ill. Oct. 27, 1989) (WESTLAW, Allfeds database);

Pinnacle Nursing Home v. Axelrod, 719 F. Supp. 1173 (W.D.N.Y. 1989);

Illinois Health Care Ass'n v. Suter, 719 F. Supp. 1419 (N.D. Ill. 1989);

AGI-Bluff Manor, Inc. v. Reagen, 713 F. Supp. 1535 (W.D. Mo. 1989);

In re Saint Joseph's Hosp., 103 Bankr. 643 (Bankr. E.D. Pa. 1989);

SSM Healthcare Systems v. Reagen, 681 F. Supp. 625 (W.D. Mo. 1988);

Friedman v. Perales, 668 F. Supp. 216 (S.D.N.Y. 1987), aff'd 841 F.2d 47 (2d Cir. 1988);

Vantage Healthcare v. Virginia Board of Medical Assistance Services, 684 F. Supp. 1329 (E.D. Va. 1988);

St. Tammany Parish Hosp. Service Dist. v. Dep't of Health and Human Resources, 677 F. Supp. 455 (E.D. La. 1988);

Bethany Medical Center v. Harder, 693 F. Supp. 968 (D. Kan. 1988), opinion amended, No. Civ. A. 85-2415-0 (D. Kan. July 1, 1988);

Montoya v. Johnston, 654 F. Supp. 511 (W.D. Tex. 1987);

Mary Washington Hosp., Inc. v. Fisher, 635 F. Supp. 891 (E.D. Va. 1985);

Arden House, Inc., v. Heintz, 612 F. Supp. 81 (D. Conn. 1985);

Hillhaven Corp. v. Wisconsin Dep't of Health and Social Services, 634 F. Supp. 1313 (E.D. Wis. 1986);

Friedman v. Perales, 616 F. Supp. 1363 (S.D.N.Y. 1985);

Hilburn v. Commissioner, Connecticut Dep't of Income Maintenance, No. H-82-200 (D. Conn. July 17, 1985) (WESTLAW, Allfeds database);

Florida Nursing Home Ass'n v. Paige, 596 F. Supp. 1152 (S.D. Fla. 1984);

Illinois Council on Long Term Care v. Miller, 579 F. Supp. 1140 (N.D. Ill. 1983);

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Illinois Council on Long Term Care v. Coler, Nos. 83-C-4812, 83-C-5245, 83-C-6574 (N.D. Ill. Sept. 24, 1984) (WESTLAW, Allfeds database);

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Fort Tryon Nursing Home v. Perales, 592 F. Supp. 819 (S.D.N.Y. 1984);

California Ass'n of Bioanalysts v. Rank, 577 F. Supp. 1342 (C.D. Cal. 1983);

In re Park Nursing Center, Inc., 28 Bankr. 793 (Bankr. E.D. Mich. 1983);

Thomas v. Johnston, 557 F. Supp. 879 (W.D. Tex. 1983);

Children's Hosp. of Philadelphia v. Secretary of Dep't of Public Welfare, 568 F. Supp. 1001 (E.D. Pa. 1983);

Michigan Hosp. Ass'n v. Department of Social Services,
555 F. Supp. 675 (E.D. Mich. 1983);

Children's Memorial Hosp. v. Illinois Dep't of Public Aid,
562 F. Supp. 165 (N.D. Ill. 1983);

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Massachusetts Hospital Ass'n, Inc. v. Harris, 500 F.
Supp. 1270 (D. Mass. 1980).

APPENDIX D
Listing of Additional Amici Curiae

Affiliates of the American Health Care Association:

Alabama Nursing Home Association
Health Association of Alaska
Arizona Health Care Association
Arkansas Health Care Association
California Association of Health Facilities
Colorado Health Care Association
Connecticut Association of Health Care Facilities
Delaware Health Care Facilities Association
District of Columbia Health Care Association
Florida Health Care Association
Georgia Health Care Association
Healthcare Association of Hawaii
Idaho Health Care Association
Illinois Health Care Association
Indiana Health Care Association
Iowa Health Care Association
Kansas Health Care Association
Kentucky Association of Health Care Facilities
Louisiana Health Care Association
Maine Health Care Association
Health Facilities Association of Maryland
Massachusetts Federation of Nursing Homes, Inc.
Health Care Association of Michigan
Care Providers of Minnesota
Mississippi Health Care Association
Missouri Health Care Association
Montana Health Care Association
Nebraska Health Care Association
Nevada Health Care Association
New Hampshire Health Care Association
New Jersey Association of Health Care Facilities
New Mexico Health Care Association
New York State Health Facilities Association
North Carolina Health Care Association

North Dakota Long Term Care Association
 Ohio Health Care Association
 Oklahoma Nursing Home Association
 Oregon Health Care Association
 Pennsylvania Health Care Association
 Rhode Island Health Care Association
 South Carolina Health Care Association
 South Dakota Health Care Association
 Tennessee Health Care Association
 Texas Health Care Association
 Utah Health Care Association
 Vermont Health Care Association
 Washington Health Care Association
 West Virginia Health Care Association
 Wisconsin Association of Nursing Homes
 Wyoming Health Care Association

Affiliates of the American Association of Homes for the Aging:

Arizona Association of Homes for the Aging
 Association of Massachusetts Homes for the Aging
 Association of Ohio Philanthropic Homes and Housing for Aging
 California Association of Homes for the Aging
 Colorado Association of Homes and Services for the Aging
 Connecticut Association of Non-Profit Facilities for Aged
 Florida Association of Homes for the Aging
 Georgia Association of Homes and Services for the Aging
 Illinois Association of Homes for the Aging
 Indiana Association of Homes for the Aging
 Iowa Association of Homes for the Aging
 Kansas Association of Homes for the Aging
 Kentucky Association of Homes for the Aging
 Louisiana Association of Homes and Services for Aging

Maryland Association of Non-Profit Homes for the Aging.
 Michigan Non-Profit Homes Association
 Minnesota Association of Homes for the Aging
 Missouri Association of Homes for the Aging
 Montana Association of Homes for the Aging
 Nation's Capital Area Association of Homes for the Aging
 New Jersey Association of Non-Profit Homes for the Aging
 New York Association of Homes and Services for the Aging
 North Carolina Association of Non-Profit Homes for the Aging
 North Dakota Nursing Home Association
 Oregon Association of Homes for the Aging
 Pennsylvania Association of Non-Profit Homes for the Aging
 Rhode Island Association of Facilities for the Aged
 South Dakota Association of Homes for the Aging
 Texas Association of Homes for the Aging
 Virginia Association of Nonprofit Homes for the Aging
 Washington Association of Homes for the Aging
 Wisconsin Association of Homes and Services for the Aging

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(1)

In the Supreme Court OF THE United States

OCTOBER TERM, 1989

**GERALD L. BALILES, et al.,
*Petitioners,***

v.

**THE VIRGINIA HOSPITAL ASSOCIATION,
*Respondent.***

**On Writ of Certiorari to the
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**BRIEF OF AMICI CURIAE
CALIFORNIA ASSOCIATION OF HOSPITALS AND
HEALTH SYSTEMS, CALIFORNIA ASSOCIATION
OF PUBLIC HOSPITALS, AND
UNITED HOSPITAL ASSOCIATION
IN SUPPORT OF RESPONDENT'S POSITION**

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No. 88-2043

**In the Supreme Court
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**BRIEF OF AMICI CURIAE
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HEALTH SYSTEMS, CALIFORNIA ASSOCIATION
OF PUBLIC HOSPITALS, AND
UNITED HOSPITAL ASSOCIATION
IN SUPPORT OF RESPONDENT'S POSITION**

INTERESTS OF AMICI CURIAE

The California Association of Hospitals and Health Systems, California Association of Public Hospitals, and United Hospital Association respectfully submit this brief in support of the position of respondent Virginia Hospital Association. The California Association of Hospitals and Health Systems ("CAHHS") is a statewide organization of non-profit, investor-owned, public, rural and district hospitals which seeks to promote the health and well-being of the residents of California. The California Association of Public Hospitals ("CAPH") is a California non-profit corporation, the members of which are public hospitals owned and operated by counties throughout California. The United Hospital Association is a California non-profit corporation which represents the interests of investor-owned hospitals in the State of California. Its purposes are to preserve the hospital as an American free enterprise institution and to coordinate efforts to furnish quality patient care at the lowest possible cost.¹

Amici have a vital interest in the proceedings in this matter because their members provide a substantial portion of inpatient and outpatient hospital services delivered under California's Medicaid program, known as "Medi-Cal," administered by the State Department of Human Services ("SDHS"). *Amici* are concerned that Congress's directive that Medicaid payment rates be "reasonable and adequate . . . to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards . . .," 42 U.S.C.A.

¹CAHHS, CAPH and UHA have requested and obtained the written consent of the parties to file this *amici curiae* brief in support of respondent's position. The letters containing the written consents are on file with the Clerk of this Court.

§ 1396a(a)(13)(A) (West Supp. 1989), has not been achieved. Although California hospitals incur an average operating expense of \$294 per day for medical/surgical acute care, the Medi-Cal program reimburses them in the average amount of \$156 per day, or 53 percent of their operating expenses. (California) Office of Statewide Health Planning and Development, *Individual Hospital Financial Data for California* at xii (1989). SDHS's Medi-Cal payments are 30 percent lower than the average daily payment made under the Medicare program, and 58 percent lower than payments made by other payor sources. *Id.* As a result of such payments, in fiscal year 1988 California hospitals lost a combined total of \$947 million for services rendered under the Medi-Cal program. (California) Office of Statewide Health Planning and Development, *Quarterly Aggregate Hospital Data for California*, 2-2, 4-2, 6-2, 8-2 (1988).

The section 1983 remedy recognized by the Fourth Circuit in the proceedings below (*Virginia Hosp. Ass'n v. Baliles*, 868 F.2d 653 (4th Cir. 1989)) and other courts of appeals is a critical mechanism by which health care providers can obtain review of payment levels established by the states. In California, as elsewhere, the administrative appeal procedure established by the state's administering agency will not examine the sufficiency of the underlying payment methods established by the agency and, in particular, whether those methods comply with federal program directives. *See* 22 Cal. Code Regs. §§ 51536(h)(1) and (i)(2), 51539(d)(2). Actions such as that brought by the Virginia Hospital Association, far from frustrating the purposes of the Medicaid program, are an efficient and logical means of assuring that Medicaid recipients obtain proper and effective medical treatment.

SUMMARY OF ARGUMENT

Earlier this year the United States Court of Appeals for the Fourth Circuit held that Virginia hospitals may, pursuant to 42 U.S.C. § 1983, challenge Virginia's methods for reimbursing them for the cost of treating Medicaid patients. *See Virginia Hosp. Ass'n v. Baliles*, 868 F.2d 653 (4th Cir. 1989). The court of appeals determined that the language and legislative history of title XIX of the Social Security Act, 79 Stat. 343, as amended, 42 U.S.C. §§ 1396 *et seq.* (known as the "Medicaid Act"), compelled the conclusion that health care providers which treat Medicaid recipients may enforce a right to a minimum level of payment under the statute. In so holding, the Fourth Circuit aligned itself with every court of appeals which has considered the issue. After the Fourth Circuit issued its decision, the Third Circuit, in *West Virginia Univ. Hosps., Inc. v. Casey*, 885 F.2d 11 (3d Cir. 1989), independently examined the statutory text and legislative history, and came to the identical conclusion that health care providers are entitled to enforce the statutory directive that payment rates for Medicaid services be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality . . ." 42 U.S.C.A. § 1396a(a)(13)(A) (West Supp. 1989).

The unanimous conclusion of these appellate courts that a health care provider may avail itself of a section 1983 remedy to ensure state compliance with the mandates of the Medicaid Act is convincingly supported by the text of the Act and its legislative history. Adhering to this Court's precedents under section 1983, the courts have first examined whether the Medicaid Act confers

certain enforceable rights on an approved health care provider which furnishes medical care under the program. The courts have correctly concluded that the Act's directives (which are coupled with substantial federal financial assistance) that each participating state establish minimum levels of reimbursement are mandatory. The courts have also examined the legislative history of the 1981 amendments to the Act, and have found a clear and unambiguous design by Congress to maintain a federal minimum standard of reimbursement, while at the same time permitting the states greater flexibility in meeting that standard. The courts have also found that an authorized provider is an intended beneficiary of the Act's payment standards, inasmuch as Congress's ultimate objective of providing care for the medically indigent depends entirely on compliance with a minimum level of provider reimbursement. (Moreover, in 1981 Congress had full knowledge that providers had sought and obtained judicial review of state payment methods, and left such avenues open to them.)

The Fourth Circuit, like the other courts of appeals which have considered this issue, also considered whether Congress specifically foreclosed a remedy under section 1983 by express provision, or by providing a comprehensive mechanism for the enforcement of provider rights under the Act. The courts are again unanimous in concluding that the compelling showing required under *Wright v. City of Roanoke Redevelopment and Hous. Auth.*, 479 U.S. 418 (1987), of a legislative intent to foreclose the use of the section 1983 remedy cannot be made in this instance. The Medicaid Act itself does not contain a provision that expressly forecloses the use of section 1983, a fact which all concede. The limited review procedures available under the program do not come close to the "comprehensive enforcement mechanism[]" from which Congress's intent to foreclose could be inferred

(*Smith v. Robinson*, 468 U.S. 992, 1003 (1984)), but are strikingly similar to the generalized federal review powers that were examined by this Court in *Wright*, and found to be insufficient to foreclose the use of section 1983.

ARGUMENT

I.

HEALTH CARE PROVIDERS HAVE A RIGHT TO REASONABLE PAYMENT FOR SERVICES RENDERED UNDER THE MEDICAID ACT THAT MAY BE ENFORCED UNDER 42 U.S.C. § 1983

This Court granted certiorari to decide whether a Medicaid provider may avail itself of the broad remedial provisions of 42 U.S.C. § 1983 to enforce a state's failure to comply with minimum standards of payment under the Medicaid Act. Section 1983 provides a remedy for "the deprivation of any rights, privileges, or immunities secured by the Constitution and laws." 42 U.S.C.A. § 1983 (West Supp. 1989). Earlier this month this Court emphasized its "repeate[d] [holdings] that the coverage of the statute must be broadly construed." *Golden State Transit Corp. v. City of Los Angeles*, No. 88-840, slip op. at 2 (Dec. 5, 1989). The statute "provides a remedy 'against all forms of official violation of federally protected rights.'" *Id.* (quoting *Monell v. New York City Dep't of Social Services*, 436 U.S. 658, 700-701 (1978)). The class of "federally protected" rights under section 1983 includes rights secured by federal statutes (*Maine v. Thiboutot*, 448 U.S. 1, 4 (1980)), and by federal regulations (*Wright*, 479 U.S. at 424-425).

This Court employs a two-step analysis to determine whether a statutory or constitutional violation may be remedied by section 1983. First, the federal law must create private rights enforceable under section 1983. *Pennhurst State School and Hosp. v. Halderman*, 451 U.S.

1, 19 (1981). Second, assuming that a federal right is involved, the defendant may establish that Congress "specifically foreclosed a remedy under 1983," *Smith*, 468 U.S. at 1005 n. 9, by providing a "comprehensive enforcement mechanis[m] for protection of a federal right." *Id.* at 1003.

The first question raised by this appeal, then, is whether the payment sections of the Medicaid Act and its implementing regulations create rights in favor of those health care providers which provide medical care under the Act. The issue is *not* — as petitioners repeatedly suggest — whether Congress intended to create an "implied right of action" under the Act. *See Brief of Petitioners* at 11, 17, 21.² Petitioners' brief confuses the related but distinct analyses of rights of action under section 1983 and implied rights of action under a substantive

²Petitioners argue throughout that neither the Medicaid Act nor the 1981 Boren Amendment evinces a congressional intent to create an "implied right of action," relying on this Court's implied right of action decisions (most notably, *Cort v. Ash*, 422 U.S. 66 (1975)). For example, petitioners state that "the implied right of action cases under § 1983 increasingly look to legislative intent to create a cause of action as the dispositive factor in determining whether § 1983 is available to enforce a violation of a federal statute against a state." *Brief for Petitioners* at 11. The ascertainment of a legislative intent "to create a cause of action" is not even relevant to an analysis under section 1983, let alone a "dispositive factor." As this Court has pointed out on numerous occasions (*see Thiboutot*, 448 U.S. at 4), section 1983 itself is a remedy expressly intended by Congress.

Petitioners' further suggestion that the absence of "an express right enforceable by a Medicaid provider against a State," *Brief of Petitioner* at 12 n. 3, may be taken as an indication of congressional intent *not* to recognize provider rights has no support in the decisions of this Court. This suggestion conflicts directly with *Thiboutot*, where the Court held that a section 1983 right of action was available to enforce the Social Security Act notwithstanding the absence of a right of action under that Act. *See* 448 U.S. at 5-6.

statute, and in so doing holds providers to a false standard. These are different inquiries which intersect only on the issue of whether the underlying statute confers an enforceable right on the plaintiff. *See Middlesex County Sewerage Auth. v. National Sea Clammers Ass'n*, 453 U.S. 1, 19 & 20 n. 31 (1981). In contrast to the showing required to establish an implied right of action, "the plaintiff who seeks to enforce a federal statutory right under section 1983 need not demonstrate congressional intent to provide access to that remedy," *Boatowners and Tenants Ass'n, Inc. v. Port of Seattle*, 716 F.2d 669, 674 (9th Cir. 1983), since "§ 1983 itself provides for private enforcement." *West Virginia Univ. Hosps.*, 885 F.2d at 18-19 n. 1. Thus, the issue here is simply whether a participating provider has a right under the Medicaid Act to a minimum level of payment.

A. The Medicaid Act Establishes a Minimum Standard of Reimbursement of Authorized Health Care Providers

A health care provider which provides medical care for Medicaid recipients has a right to be paid in accordance with minimum standards of reimbursement. This conclusion is supported by the text of the Medicaid statute, the pertinent legislative history, and the implementing regulations of the Health Care Finance Administration ("HCFA"), the agency within the Department of Health and Human Services responsible for overseeing the Medicaid program.

As petitioners have pointed out, the Medicaid statute is extraordinarily complex. One of the main reasons for this complexity is the number of parties which have a role in the system, and the concomitant necessity of coordinating various responsibilities among them. The states, of course, do not directly furnish care for Medicaid recipients, but instead rely upon qualified health care providers. Earlier this year the Third Circuit aptly

characterized the Medicaid Act as a "cooperative mosaic through which the federal government reimburses a portion of the payments made by participating states to hospitals and other providers furnishing care to eligible needy persons." *West Virginia Univ. Hosps.*, 885 F.2d at 19.

A state that chooses to participate in the program is obligated to develop a state Medicaid plan that complies with federal statutory and regulatory conditions of funding. These conditions are numerous, and are contained in no less than fifty subsections of section 1902(a). It is difficult to conceive of a more comprehensive set of program standards. A state's plan must contain methods of administration "as are found by the Secretary to be necessary for the proper and efficient operation of the plan" (§ 1396a(a)(4)(A)); designate a single state agency to administer the plan (§ 1396a(a)(5)); ensure that medical assistance is available to individuals who qualify under any one of several qualifying provisions (§ 1396a(a)(10)(A)); and provide for reports to the Secretary "as the Secretary may from time to time require." (§ 1396a(a)(6).)

A number of state plan requirements expressly concern reimbursement for services furnished under the Act. In this case the Virginia Hospital Association has alleged that Virginia has failed to comply with section 1902(a)(13)(A), 42 U.S.C. § 1936a(a)(13)(A), one of a number of sections that concern payments to providers. This subsection provides, in pertinent part:

A State plan for medical assistance must —

...

(13) provide —

(A) for payment . . . of the hospital . . . services provided under the plan through the use of rates (determined in accordance with methods and

standards developed by the State and which, in the case of hospitals, take into account the situation of hospitals which serve a disproportionate number of low income patients with special needs . . .) which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the cost which must be incurred by efficiently and economically operated facilities . . .

42 U.S.C.A. § 1396a(a)(13)(A) (West Supp. 1989) (emphasis supplied). Subsection (30)(A) stipulates that the state plan "provide such methods and procedures relating to . . . the payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care . . ." 42 U.S.C.A. § 1396a(a)(30)(A) (West Supp. 1989).³ Provider reimbursement is also addressed in subsection 37(B), which requires the Medicaid agency to provide "procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program . . ." 42 U.S.C.A. § 1396a(a)(37)(B) (West Supp. 1989).

The payment sections of the statute, like all of the Act's requirements for state administration, are cast in the imperative. Each provision is prefaced with the directive that "[a] State plan for medical assistance must . . ." "The language succinctly sets forth a congressional command, which is wholly uncharacteristic of a mere suggestion or 'nudge' . . . in the direction of providing

³Although the Virginia Hospital Association's pleading in the District Court does not contain a subsection (30)(A) claim, such a claim would appear available to it on the basis of the facts alleged.

appropriate reimbursement of hospitals treating Medicaid patients." *West Virginia Univ. Hosps.*, 885 F.2d at 20.

Even if the plain language of the statute were not so clear, the legislative history confirms Congress's purpose to maintain minimum reimbursement standards. Prior to the enactment of the 1981 Boren Amendment, the law required each participating state to reimburse providers on a "reasonable cost" basis for inpatient services under Medicaid. This method of reimbursement was thought to result in unnecessarily high program costs. See H.R. Rep. No. 97-158, 97th Cong., 1st Sess. 279, 292 (1981). Congress believed that states should be given the flexibility to develop "alternative reimbursement methodologies that promote the efficient and economic delivery of such services." *Id.* By granting states more latitude in setting payment rates, however, Congress did not thereby intend to eliminate federal payment standards. Rather, Congress substituted new reimbursement standards.⁴ This is clear from the House Budget Committee's comments on H.R. 3982, the bill that ultimately became Public Law 97-35:

This section eliminates the current requirement that States pay hospitals on a Medicare 'reasonable cost' basis for inpatient services under Medicaid. The Committee bill requires instead that Medicaid payments be 'reasonable

⁴Petitioners misinterpret a congressional design for greater state flexibility as a complete abdication of federal standards. See Brief for Petitioners at 20 (The 1981 Boren Amendment reflects a "legislative choice to allow state-specific latitude in determining appropriate methodologies for payments to providers.") While Congress's purpose to grant greater flexibility to the states cannot be doubted, it does not follow that Congress thereby proposed to relieve states of their obligation to establish minimum standards of reimbursement necessary to achieve the program's objectives. In fact, the legislative history plainly indicates Congress's contrary intent.

and necessary to the efficient and economical delivery of services.'

Id. at 292 (emphasis supplied).

The Senate also intended the new standards to be binding on the states. The Report of the Conference Committee noted that the Senate bill would fix new federal reimbursement standards:

The Senate amendment also repeals the current law provision. It requires that State payments for inpatient hospital services be 'reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities' in order to meet applicable laws and quality and safety standards.

H.R. Rep. No. 97-208, 97th Cong., 1st Sess. 962 (reprinted in 1981 U.S. Code Cong. & Ad. News 396, 1324) (emphasis supplied).⁵

⁵Despite these clear expressions of Congress's intent, petitioners argue that it may be inferred from the "contemporary legal context" at the time of the 1981 Boren Amendment that Congress did not intend to confer rights on providers. See Brief of Petitioners at 21-22. There are several problems with this argument. First, it improperly incorporates analysis from this Court's "implied right of action" decisions, an error that has been previously pointed out. See pp. 6-7, *supra*, & n. 2. Second, to the extent this argument has any relevance in the section 1983 context, it cuts in favor of providers. At the time of Congress's deliberation on amendments to the Medicaid Act, a number of providers had brought actions challenging various aspects of state program administration. See *Minnesota Ass'n of Healthcare Facilities, Inc. v. Minnesota Dep't of Public Welfare*, 602 F.2d 150, 152 (8th Cir. 1979) (nursing home providers had standing to assert claim that state Medicaid regulations violated the Social Security Act); *California Hosp. Ass'n v. Obledo*, 602 F.2d 1357, 1361 (9th Cir. 1979) (ceiling on reimbursable costs did not violate Medicaid Act but federal approval of the plan did not satisfy the Act's requirements); *Massachusetts General Hosp. v. Weiner*, 569 F.2d 1156, 1161 (1st Cir. 1978) (provider challenge to Medicaid reimbursement rates failed on

The mandatory character of the Act's payment standards is confirmed in the governing regulations. HCFA interprets section 1902(a)(30) to "require[] that payments for services be consistent with efficiency, economy, and quality of care." 42 C.F.R. § 447.200 (1988) (emphasis supplied). To satisfy this requirement, "[t]he agency's payments *must* be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population." 42 C.F.R. § 447.204 (1988) (emphasis supplied). The regulations also call for each state Medicaid agency to make annual findings that its payment rates "are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated providers to provide services in conformity with applicable State and Federal laws, regulations

the merits); *Alabama Nursing Home Ass'n v. Califano*, 465 F. Supp. 1183, 1187, 1189 (D. Ala. 1979) (considering merits of claim of inadequate Medicaid reimbursement by nursing home facilities), *rev'd in part, vacated in part, Alabama Nursing Home Ass'n v. Harris*, 617 F.2d 388 (5th Cir. 1980); *Briarcliff Haven, Inc. v. Department of Human Resources*, 403 F. Supp. 1355, 1364 (D. Ga. 1975) (challenge to reimbursement provisions of the Medicaid Act failed on the merits); *Massachusetts General Hosp. v. Sargent*, 397 F. Supp. 1056, 1062 (D. Mass. 1975) (delay of reimbursement for inpatient care violated Medicaid Act); *Opelika Nursing Home, Inc. v. Richardson*, 356 F. Supp. 1338, 1345 (D. Ala. 1973) (challenge to regulation limiting payment under the Medicaid program denied on the merits). Implicit in each of these cases was that Medicaid providers had enforceable rights under the Medicaid program that could be enforced in federal court. Cf. *Thiboutot*, 448 U.S. at 5-6 (prior Social Security Act decisions necessarily relied on § 1983 as the exclusive statutory cause of action). Congress, of course, was aware of these decisions, and did nothing in either the 1980 or 1981 amendments prospectively to curtail such claims. Although in 1981 Congress revised the payment *standards* for inpatient services, it did not modify the basic statutory framework, which it well understood had enabled providers to obtain federal court review of payment levels.

and quality and safety standards...." 42 C.F.R. § 447.253(b)(1)(i) (1988). HCFA also requires each state to verify that payment rates for inpatient hospital services are "adequate to assure that recipients have reasonable access, taking into account geographic location and reasonable travel time, to inpatient hospital services of adequate quality." § 447.253(b)(1)(ii)(C) (1988).

The mandatory directives set forth in § 1396a contrast sharply with the text examined by this Court in *Pennhurst*. There, the Court was justifiably concerned that "indeterminate" statutory phrases such as "appropriate treatment" in the "least restrictive environment" to confer enforceable rights upon mentally retarded individuals would lead to consequences unforeseen by Congress and the states. The Court noted that "Congress fell well short of providing clear notice to the states that they, by accepting funds under the [Developmentally Disabled and Bill of Rights] Act, would indeed be obligated to comply with" the section of the Act under which the plaintiffs claimed a right. 451 U.S. at 25. The Court was particularly disturbed by the fact that Congress had provided the states \$1.6 million, "a sum woefully inadequate to meet the enormous financial burden," *id.* at 24, that would be imposed on the states if the Act were construed to establish enforceable rights. The Court concluded that the "Bill of Rights" portion of the Act did not create rights that could be enforced under section 1983, but indicated a mere "congressional preference for certain kinds of treatment." 451 U.S. at 19.

This is not a *Pennhurst* case. Unlike the generalized preferences expressed in the statute under review in *Pennhurst*, "[t]here can be no mistaking that the stipulations of section 1396a(a) clearly constitute conditions that a state must meet to participate in the joint pro-

gram." *West Virginia Univ. Hosps.*, 885 F.2d at 20.⁶ Eloquent testimony to this fact is found in the *amici curiae* brief of 46 states, in which the states freely acknowledge that their participation in the program carries with it an obligation to adhere to federal payment standards:

[T]he court [of appeals] ignored the equally plain Congressional insistence on 'proper accountability' to ensure that payment rates are, in fact, reasonably adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with minimal state and federal quality of care requirements and insure access to health care by Medicaid beneficiaries. *See S. Rep. 96-471*, at 29.

Brief Amici Curiae of the States of Connecticut, et al., at 15.

Moreover, the Court's understandable concern in *Pennhurst* that states receive adequate federal financial assistance comparable to the breadth of the obligation assumed obviously has no application in this context — as the Solicitor General points out, the federal government pays between 50 and 83 percent of the total cost of patient care. In fiscal 1988 alone, the federal contribution to the Medicaid program totaled \$29 billion. *See Brief of the United States* at 2; *see also Brief Amici Curiae of the*

⁶This conclusion has been reached by every court of appeals to have considered the matter. *See Amicus (PSL), Inc. v. Colorado Dep't of Social Services*, 879 F.2d 789, 793, 794 (10th Cir. 1989); *Virginia Hosp. Ass'n*, 868 F.2d at 658; *Coos Bay Care Center v. Oregon*, 803 F.2d 1060, 1063 (9th Cir. 1986), cert. granted, 481 U.S. 1036, vacated as moot, 483 U.S. 1054 (1987). *See also St. Michael Hosp. of Franciscan Sisters, Milwaukee, Inc. v. Thompson*, No. 98-C-0620-C (W.D. Wis. Oct. 25, 1989) (available Dec. 15, 1989, on LEXIS, Genfed library, Dist file) (providers are beneficiaries of Medicaid Act by virtue of direct financial interest in rates established by states).

States of Connecticut, *et al.*, at vi n. 4 (federal share of program expenditures in 1986 was 58 percent). In this case Congress gave clear notice to the states that in voluntarily agreeing to participate in the Medicaid program, the states must adhere to minimum standards of payment, and has assisted the states in the attainment of this standard with a substantial financial commitment.

B. The Federal Courts Are Competent to Enforce the Reimbursement Standards of the Medicaid Act

Petitioners and *amici* urge that the Medicaid Act's payment standards are not sufficiently "specific and definite" to give rise to enforceable rights. *See Brief of Petitioners* at 12-17; *Brief for the United States* at 13, 17.

The "specific and definite" formulation originated in this Court's *Wright* opinion. But as this Court recently made clear in *Golden State Transit*, the criterion is not one of abstract specificity; rather, the test is pragmatic, and simply asks whether the obligation sought to be enforced is "'sufficiently specific and definite' to be within 'the competence of the judiciary to enforce'" *Golden State Transit*, slip op. at 5 (quoting *Wright*, 479 U.S. at 432). In fact, the obligation sought to be enforced need not even be expressly stated. As this Court explained in *Golden State Transit*:

A rule of law that is the product of judicial interpretation of a vague, ambiguous or incomplete statutory provision is no less binding than a rule that is based on the plain meaning of a statute. The violation of a federal right that has been found to be implicit in a statute's language and structure is as much a 'direct violation' of a right as is the violation of a right that is clearly set forth in the text of the statute.

Golden State Transit, slip op. at 8-9.

Petitioners' reliance on *Wright* is ironic, since in that case the Court rejected a similar charge that the statute was "too vague and amorphous" to establish enforceable rights. Petitioners argue that the "broad standard of 'reasonable and adequate'" established by subsection 13(A) "is not the kind of language Congress has used to create an enforceable right." Petitioners' Brief at 13. But it is precisely the "kind of language" that established the right recognized in *Wright*. There the Court rejected the argument that a requirement for a "reasonable allowance for utilities" is insufficiently definite, holding that such a provision is not "beyond the competence of the judiciary to enforce."⁷ 479 U.S. at 432.

There is no need to speculate whether the payment standards of the Medicaid Act are sufficiently "specific and definite" for the judiciary to enforce. In practice the lower courts, when reviewing state agency plans and reimbursement methods, have proved themselves fully capable of determining whether the statutory standard has been satisfied. See *West Virginia Univ. Hosps.*, 885 F.2d at 30 (dual reimbursement system, under which out-of-state provider recovered only 54% of its treatment costs, fails to meet the reasonable and adequate requirement of subsection (13)(A)); *Amisub*, 879 F.2d at 799 ("overwhelming evidence" supports conclusion that application of across-the-board 46% reduction in Medicaid

⁷Petitioners and amici also stress language from the court of appeals' decision in *Edwards v. District of Columbia*, 821 F.2d 651 (D.C. Cir. 1987), reading *Penahurst* "to distinguish statutory provisions that announce broad policy goals or general preferences from those that dictate specifically what the relevant government officials may and may not do." 831 F.2d at 656. Despite the further claim by these parties that this distinction precludes the recognition of enforceable rights in the Medicaid Act, *Edwards* itself cited section 1902(a)(13)(A) as an example of "narrow language of obligation" sufficient to secure rights under federal law. See 821 F.2d at 656 n. 5.

reimbursement does not reasonably or adequately compensate hospitals); *Mississippi Hosp. Ass'n v. Heckler*, 701 F.2d 511, 518, 521 (5th Cir. 1983) (state plan complied with federal standards except for amendment disallowing certain legal fees and costs); *Ohio State Pharmaceutical Ass'n v. Creasy*, 587 F. Supp. 698, 707, 709 (S.D. Oh. 1984) (pharmacy dispensing fees were not so arbitrary and unreasonable as to violate the Act; however, delay in reimbursement of pharmacies violated section 1902(a)(37)); *Illinois Hosp. Ass'n v. Illinois Dep't of Public Aid*, 576 F. Supp. 360, 362, 373 (N.D. Ill. 1983) (22 percent reduction in hospital reimbursement from prior year violated § 1902(a)(13)(A) and (a)(30)); *California Hosp. Ass'n v. Schweiker*, 559 F. Supp. 110, 116 (C.D. Cal. 1982) (California's proposed rates were not reasonable and adequate to meet the costs of efficiently and economically operated hospitals), aff'd, 705 F.2d 466 (9th Cir. 1983). In actual practice, therefore, the minimum reimbursement standards contained in the Medicaid Act have been well within the competence of the federal courts to enforce.⁸

⁸Judicial review of agency ratemaking did not begin with the Medicaid program. Federal courts have been frequently called upon to determine whether rates established by administrative agencies satisfy statutory directives no more "specific and definite" than the Medicaid Act's reimbursement standards. See, e.g., *Mobil Oil Corp. v. Federal Power Comm'n*, 417 U.S. 283, 301 (1974) (oil company challenged natural gas rates set by Federal Power Commission under Natural Gas Act requirement that rates be "just and reasonable"); *Atchison, Topeka & Santa Fe Ry. Co. v. Wichita Board of Trade*, 412 U.S. 800, 802, 813 (1973) (grain shippers alleged rate increases approved by Interstate Commerce Commission violated Interstate Commerce Act requirement that rates be "just and reasonable"); *Swift & Co. v. United States*, 343 U.S. 373, 375 (1952) (meat packer alleged rates approved by Interstate Commerce Commission violated Interstate Commerce Act requirement that carriers establish "just and reasonable charges"); *United States v. Chicago, Milwaukee,*

C. The Medicaid Act's Minimum Payment Standards Are Designed to Benefit Recipients and Providers

Petitioners and certain *amici* contend that health care providers which treat Medicaid patients have no rights under the Medicaid Act because the Act was not designed for their benefit. This argument does not take proper account of the critical role of health care providers within the Medicaid delivery system. The argument, moreover, proceeds from the flawed premise that a federal statute cannot benefit multiple parties.

Health care providers occupy a central role in the Medicaid system. It cannot be gainsaid that one of Congress's principal objectives, if not its principal purpose, was to provide medical care for the poor. Congress also recognized, however, that its purpose could not be achieved unless the states established payment rates sufficient to attract providers to the program, and to meet the costs reasonably incurred by providers in rendering medical assistance. This much is plain from the text of the statute, which requires that payment rates "meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services" under the program, and are sufficient "to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality." 42 U.S.C.A. § 1396a(a)(13)(A) (West Supp. 1989). The concept is also embodied in the further directive that the states employ payment methods and procedures "as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care . . ." § 1396(a)(30)(A) (West Supp. 1989). Simi-

St. Paul & Pacific R.R. Co., 294 U.S. 499, 505 (1935) (coal shippers challenged schedule of rates set by Interstate Commerce Commission for the transportation of bituminous coal as not meeting "just and reasonable" requirement of Interstate Commerce Act).

larly, subsection 37 requires the states to adopt claims review procedures that "ensure the proper and efficient payment of claims and management of the program . . ." § 1396a(a)(37). Thus, the specific purposes of subsections (13)(A) and (30)(A) — the establishment of adequate reimbursement levels — may be taken as subsidiary but necessary steps in the attainment of the Congress's ultimate objective.

The courts of appeals uniformly have concluded that these sections establish a minimum standard of reimbursement in favor of providers. As the Third Circuit cogently put the matter:

We recognize, of course, that the primary purpose of medicaid is to achieve the praiseworthy social objective of granting health care coverage to those who cannot afford it. It does not necessarily follow, however, that Title XIX grants substantive rights *only* to medicaid patients. Although the broad purpose of the Medicaid Act as a whole is to help the poor attain medical care, the specific purpose of section 1396a(a)(13)(A) is to assure state compliance with some federal standard of hospital reimbursement. The section sets up a plan for the adequate and reasonable reimbursement of hospitals which serve medicaid patients, and thus the hospitals are the section's beneficiaries.⁹

West Virginia Univ. Hosps., 885 F.2d at 20 (original emphasis). Other courts have spoken of the "parallel interests" of providers and patients in minimally adequate Medicaid payment rates. See *Coos Bay Care Center*, 803 F.2d at 1063.¹⁰

⁹The courts have occasionally relied on the self-interest of one class of persons to serve the interests of another class. In *Singletary v. Wulff*, 428 U.S. 106 (1976), the Court held that two Missouri physi-

The legislative history of the 1981 Boren Amendment provides compelling support for this view. Congress plainly understood that minimum payment rates were necessary for the success of the Medicaid program. The Report of the House Budget Committee on H.R. 3982 reveals an unambiguous intent that providers receive fair and adequate reimbursement under the program. As the Committee stated:

In permitting States greater flexibility in reimbursement system design, the Committee intends the States to ensure that such alternative systems provide fair and adequate compensation for services to Medicaid beneficiaries. The Committee intends that reimbursement levels for inpatient services must be adequate to assure that a sufficient number of facilities providing a sufficient amount of services actively participate in the Medicaid program to enable all Medicaid beneficiaries to be able to obtain quality inpatient services for the treatment of their medical conditions. . . . *The Committee would be extremely concerned to see a substantial reduction in hospitals' willingness to treat Medicaid patients as a result of payment policy changes.*

cians had standing to challenge the constitutionality of a Missouri Medicaid statute which excluded abortions that were not "medically indicated" from the purposes for which Medicaid benefits were available to needy persons. *See also Comtronics, Inc. v. Puerto Rico Tele. Co.*, 533 F.2d 701, 704-705 (1st Cir. 1977) (communications suppliers within the class of intended beneficiaries protected by § 203(b) of the Communications Act because, *inter alia*, suppliers vindicate consumer interest); *Planned Parenthood of Billings, Inc. v. Montana*, 648 F. Supp. 47, 50 (D. Mont. 1986) (family planning service has reinforceable rights under Public Health Service Act, a statute designed to improve availability of family planning services through the provision of grants).

The Committee believes that hospitals should be paid for the cost of their care to Medicaid patients in the most economical manner. The Committee intends States to recognize that facilities that provide teaching services or other specialized tertiary care services that may have operating costs which exceed those of a community hospital. The Committee is concerned that the reimbursement methods established by the States recognize the need to provide a full range of both primary care and tertiary care services to Medicaid beneficiaries and take into account the differences in operating costs of the various types of facilities needed to provide this broad scope of services . . .

Thus, while the Committee recognizes that in this time of economic constraint and reductions in Federal funds for Medicaid, States must be given the flexibility necessary to improve the Medicaid reimbursement mechanism, the Committee does not want such policies to result in arbitrary and unduly low reimbursement levels for hospital services.

H.R. Rep. No. 97-158, 97th Cong., 1st Sess. 279, 293-294 (1981) (emphasis supplied).

The Committee expressed particular concern with the circumstances of providers which treat a disproportionate percentage of program recipients, such as the public hospitals that comprise *amicus* CAPH. The Committee directed that such providers receive fair and adequate compensation under the program:

The Committee is also concerned about the impact of the States [sic] payment practices on facilities that treat a large volume of Medicaid patients and patients who are not covered by other third party payors. The Committee intends

that payment for inpatient services take into account the special costs of hospitals whose patient populations are disproportionately composed of such individuals.

Therefore, the Committee bill requires that States, in determining the appropriate reimbursement rate for inpatient hospital services, and in developing a prospective payment methodology, take into account the special costs of hospitals whose patient populations are disproportionately composed of individuals who are either provided medical assistance under the State plan or who have no source of third party payment for such services.

Id. at 294-295.

There is no question that the Committee was concerned with the financial well being of such providers, independent of their role within the Medicaid delivery system. In directing the Secretary of Health and Human Services to develop reimbursement methods "based on the complexity and severity of cases treated at each hospital," and to "analyze the impact of the reimbursement methodology . . . on the financial viability of institutions whose patient populations are disproportionately composed of Medicaid patients or patients without third party coverage." *Id.* at 297 (emphasis supplied).

The Boren Amendment, as passed, incorporated much of H.R. 3982. Indeed, the Secretary relied extensively on the Budget Committee Report in formulating the Act's interim regulations. See 46 Fed. Reg. 47964, 47969 (1981). The Conference Committee on the Boren Amendment shared these concerns. In its report, the Committee expressed its intent that state payment rates adequately compensate hospitals for the care of Medicaid patients:

[T]he conferees intend that State hospital reimbursement policy should meet the costs that must be incurred by efficiently-administered hospitals in providing covered care and services to Medicaid eligibles as well as the costs required to provide care in conformity with State and Federal requirements.

H.R. Rep. No. 97-208, 97th Cong., 1st Sess. 962 (reprinted in 1981 U.S. Cong. & Ad. News 1010, 1324). The Conference Committee was also concerned that so-called "disproportionate share" hospitals receive adequate reimbursement from the States:

The conferees recognize that public hospitals and teaching hospitals which serve a large Medicaid and low income population are particularly dependent on Medicaid reimbursement, and are concerned that a state take into account the special situation that exists in these institutions in developing their rates.

Id.

In sum, notwithstanding Congress's purpose to give the states added flexibility in establishing payment rates, Congress was equally concerned that payment rates meet the costs that must be incurred by efficiently and economically operated hospitals, and take into account the circumstances of disproportionate share providers. These concerns "impl[y] an intent to supply hospitals with an indispensable right to enforce state compliance with federal standards that, whether strictly or loosely, govern state reimbursement methodologies." *West Virginia Univ. Hosps.*, 885 F.2d at 21.

HCFA also recognizes that providers have certain rights under the Medicaid system. Applying subsection 37 of the Act, in 1984 HCFA adopted regulations requiring each administering agency to "provide an appeals or

exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates." 42 C.F.R. § 447.253(e) (1988). See 48 Fed. Reg. 56046, 56052 (1983). The agency observed that the purpose of the appeals process was to permit providers to challenge payment rates established by the state:

The intent behind the Federal appeals provision is to provide a means for facilities to seek reimbursement relief upon a proper finding by the State agency... We believe that fair and reasonable rate adjustments are implicit in an appeals process.

48 Fed. Reg. at 56052 (1983).¹⁰

It is plain from subsection 37(B), HCFA's implementing regulations and HCFA's explanatory remarks that HCFA understands providers to have certain rights of review under the Act. An appeals mechanism for providers only makes sense if providers have certain "rights" on which to base an appeal. As HCFA's own regulations state, "fair and reasonable rate adjustments are implicit in an appeals process"

¹⁰If providers are not entitled to bring federal court actions to enforce rights recognized under section 1902(a), it would presumably be left to the indigent program recipients to bring such actions. In fact, as shown on Appendix A to the brief of *Amici Curiae States*, program beneficiaries and organizations that represent them rarely bring such cases. Absent the right of a healthcare provider to obtain judicial review of the adequacy of Medicaid payment rates, such a challenge would only be brought on the basis of hospital-by-hospital year-by-year administrative appeals. Hospitals often elect not to pursue such appeals because of the costs and burdens of the process.

II.

CONGRESS HAS NOT SPECIFICALLY FORECLOSED SECTION 1983 ENFORCEMENT OF THE MEDICAID ACT'S REIMBURSEMENT STANDARDS

Petitioners and certain *amici* also contend that "congressional intent to foreclose a federal cause of action can be implied" from the existence of "federally mandated appeals procedures." See Brief of Petitioners at 22-26. The limited review procedures available under the program, however, do not approach the "comprehensive enforcement mechanis[m] for protection of a federal right," *Smith*, 468 U.S. at 1003, from which an intent to foreclose use of section 1983 can be inferred.

A compelling showing is required to establish that Congress intended to foreclose a private remedy under section 1983. The Court does "not lightly conclude that Congress intended to preclude reliance on § 1983 as a remedy" for the deprivation of a federally secured right." *Wright*, 479 U.S. at 423-424 (quoting *Smith*, 468 U.S. at 1012). "[I]f there is a state deprivation of a 'right' secured by a federal statute, § 1983 provides a remedial cause of action unless the state actor demonstrates by express provision or other specific evidence from the statute itself that Congress intended to foreclose such private enforcement." *Wright*, 479 U.S. at 423. In the absence of an express provision, congressional intent to foreclose has usually been found in the establishment of a comprehensive remedial scheme. See, e.g., *Sea Clammers*, 453 U.S. at 20; *Smith*, 468 U.S. at 1012.

The Medicaid Act contains no provision that expressly forecloses the use of the section 1983 remedy. Although Congress has established some review procedures, these procedures are not "sufficiently comprehensive . . . to demonstrate Congressional intent to preclude the remedy of suits under § 1983." *Wright*, 479 U.S. at 424 (quoting *Sea Clammers*, 453 U.S. at 20).

There are two potential means by which a state's failure to establish reasonable payment rates may be enforced. First, as previously discussed, the implementing regulations require the state administering agency to provide an appeals procedure "that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates." 42 C.F.R. § 447.253(e) (1988). However, "the existence of a state administrative remedy does not ordinarily foreclose resort to § 1983." *Wright*, 479 U.S. at 427-28 (citing *Patsy v. Board of Regents*, 457 U.S. 496, 516 (1982)). This principle applies with particular force here, where the regulations vest the state administrative agency with substantial discretion to confine the "issues" on which an appeal will be permitted. The Court of Appeals found, in fact, that Virginia's appeals system does not permit consideration of some of the arguments made in VHA's complaint. *See* 868 F.2d at 661 n. 9.¹¹

The Act also permits the Secretary of Health and Human Services to discontinue federal funding if a state plan does not meet the program requirements. *See* 42 U.S.C.A. § 1396c (West Supp. 1989). Under *Wright*, however, "considerable authority to oversee the operation" of the program, and even the power to cut off federal funds,

¹¹A limited scope of review is not unique to Virginia's appeal system. Pennsylvania's appeals procedure permits providers to challenge the *application* of the state's reimbursement methodology, but not the validity of the methodology itself. *See West Virginia Univ. Hosps., Inc. v. Casey*, 701 F. Supp. 496, 510 (M.D. Pa. 1988), *aff'd in part, rev'd in part*, 885 F.2d 11 (3d Cir. 1989). The same is true in California. *See* 22 Cal. Code Regs. § 51536(h)(1) & (i)(2) (provider may not pursue administrative adjustment or appeal of methods used for determining rate factors, or use of certain limitations on payment rates); § 51539(d)(2) (agency's use of payment limiting regulation not subject to administrative review or adjustment).

are mere "generalized powers [that] are insufficient to indicate a congressional intention to foreclose § 1983 remedies." *Wright*, 479 U.S. at 424, 428. *See West Virginia Univ. Hosps.*, 885 F.2d at 22 ("Title XIX gives no indication that the cut-off of funds to the federal agency is intended to supplant a section 1983 remedy.").

Petitioners contend that Congress's intent to foreclose a section 1983 action may be divined from HCFA's "comprehensive program of ongoing state plan reviews [and] audits . . ." Brief for Petitioners at 24. Indeed, petitioners assert that "HCFA vigorously enforces the Medicaid Act," *id.* at 23, and that its "oversight is more direct, more intense and doubtless more effective than the casually-exercised HUD powers found in *Wright* to be insufficient to indicate legislative foreclosure of § 1983 remedies." *Id.* at 24 n. 17.

In fact, HCFA's oversight is neither "comprehensive" nor "intensive," either in design or in operation. HCFA's review of payment methods contained in a state's Medicaid plan is "cursory at best. In essence, its review is limited to whether the documentation submitted by the State Medicaid Agency complies with procedural requirements." *Amisub*, 879 F.2d at 794. The agency does not "look behind" the State's [assurances] concerning the adequacy of its reimbursement rate." *West Virginia Univ. Hosps.*, 701 F. Supp. 496, 510 (M.D. Pa. 1988) (finding of fact no. 201), *aff'd in part, rev'd in part*, 885 F.2d 11 (3d Cir. 1989); *see also Amisub (PSL), Inc. v. State of Colorado Dep't of Social Services*, 698 F. Supp. 217, 219 (D. Colo. 1988) (HCFA's review of Colorado's payment rates is "cursory" and is limited to determination whether documentation supplied by the agency complies with procedural requirements), *rev'd on other grounds*, 879 F.2d 789 (10th Cir. 1989).

Indeed, a compelling refutation of petitioner's assertions is contained in the Brief of the Solicitor General, a

brief ironically submitted in support of Virginia's position. The unambiguous theme that emerges from the Solicitor General's brief is that Congress intended HCFA to exercise *minimal* review of State payment methodologies. For example, the Solicitor General claims that "[i]n enacting the Boren Amendment . . . Congress made clear that it did not envision rigorous Federal scrutiny of the State's 'assurances' under Section 1396a(a)(13)(A)," Brief of United States at 20, and that "[c]onsistently with this legislative history, the Secretary has maintained that Section 1396a(a)(13)(A) does not require him to analyze or verify the State's findings, but only to satisfy himself that there is a reasonable basis on which the State's assurances may be accepted." *Id.* at 21. This does not describe an enforcement mechanism "sufficiently comprehensive and effective to raise a clear inference that Congress intended to foreclose a section 1983 cause of action." *Wright*, 479 U.S. at 425.

Petitioners and *amici* also argue that recognition of a section 1983 remedy would be duplicative, wasteful of resources or result in thousands of routine cases being brought.¹² This claim is not borne out by the facts. Since the inception of the Medicaid program in 1966, *amici* have found only 84 reported cases in all federal and state courts involving claims by providers to enforce payment rights under section 1902(a) of the Act.

A hospital-by-hospital pursuit of administrative remedies followed by judicial review as suggested by petitioners (at 9-10) and *amici* would almost certainly add substantially to the number of Medicaid challenges and the burden of states in responding to them.¹³ That only 31

¹²Brief of Petitioners at 24-25; Brief of United States at 2-3, 23; Brief of *Amici Curiae* States at v-vi & n. 2

¹³The litigation strategy advocated by petitioners and particularly by *Amicus* United States would potentially lead to an abuse of the

currently pending cases exist on various Medicaid issues, involving 18 separate state Medicaid plans, testifies to the relative paucity of such litigation. See Appendix A to Brief of *Amici Curiae* States. In this case, a single action by the Virginia Hospital Association seeks to vindicate rights on behalf of almost all of the hospitals in the state. Joint Appendix at 5. Short of eliminating litigation altogether, it is difficult to conceive of a more efficient use of state resources required to respond to Medicaid challenges.

judicial system. As an example, the Secretary under the analogous Medicare program required literally thousands of administrative appeals, scores of federal court actions, and eleven federal courts of appeals to address a single payment issue involving a hospital's right to reimbursement of malpractice insurance costs. See *Mason General Hosp. v. Secretary of Dep't of Health and Human Services*, 809 F.2d 1220, 1223 n. 2 (6th Cir. 1987) and cases cited therein; see also *Tallahassee Memorial Regional Medical Center v. Bowen*, 815 F.2d 1435 (11th Cir. 1987), cert. denied, ____ U.S. ____ (1988); *Bethesda Community Hosp. v. Bowen*, 810 F.2d 558 (2d Cir. 1986), *rev'd*, ____ U.S. ____ (1988); *Walter O. Boswell Memorial Hosp. v. Heckler*, 749 F.2d 788 (D.C. Cir. 1985). As a result of the Secretary's requirement that each hospital separately pursue its administrative claims regarding payment of malpractice insurance costs, over 80 such cases were filed in U.S. District court for the District of Columbia since 1982. See, e.g., *Walter O. Boswell Memorial Hosp. v. Heckler*, Civil Action No. 82-0710 and cases consolidated with it; *Ardmore Adventist Hosp. v. Sullivan*, Civil Action No. 85-2841 and cases consolidated with it.

CONCLUSION

The judgment of the United States Court of Appeals for the Fourth Circuit should be affirmed.

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California Association of Hospitals and Health Systems,
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December 20, 1989

PROOF OF SERVICE BY MAIL

STATE OF CALIFORNIA }
 COUNTY OF LOS ANGELES } ss.:

I am a citizen of the United States and a resident of or employed in the City of Los Angeles, County of Los Angeles; I am over the age of 18 years and not a party to the within action; my business address is 1706 Maple Avenue, Los Angeles, California 90015.

On December 20, 1989, I served the within Brief of *Amici Curiae* in re: "Gerald L. Baliles v. The Virginia Hospital Association" in the United States Supreme Court, October Term 1989, No. 88-2043, on all parties interested in said action, by placing three true copies thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mail box at Los Angeles, California, addressed as follows:

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All parties required to be served have been served.

I declare under penalty of perjury under the laws of the
United States that the foregoing is true and correct.

Executed on December 20, 1989, at Los Angeles,
California.

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CE CE MEDINA

DEC 20 1989

JOSEPH F. SPANOL, JR.

RECEIVED

No. 88-2043

In The Supreme Court of the United States
OCTOBER TERM, 1989

GERALD L. BALILES,
et al.

Petitioners,

v.

THE VIRGINIA HOSPITAL ASSOCIATION
Respondent.

**BRIEF AMICUS CURIAE OF TEMPLE UNIVERSITY—
OF THE COMMONWEALTH SYSTEM OF
HIGHER EDUCATION IN SUPPORT OF
THE RESPONDENT.**

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QUESTION PRESENTED

Whether a Medicaid provider has a private federal cause of action under 42 U.S.C. § 1983 to enforce the Medicaid Act against a State.

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GERALD L. BALILES,
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THE VIRGINIA HOSPITAL ASSOCIATION
Respondent.

BRIEF AMICUS CURIAE OF TEMPLE UNIVERSITY—
OF THE COMMONWEALTH SYSTEM OF
HIGHER EDUCATION IN SUPPORT OF
THE RESPONDENT.

INTEREST OF AMICUS CURIAE

Amicus Temple University—Of the Commonwealth System of Higher Education (“Temple”)¹ operates Temple University Hospital and is the largest provider of inpatient hospital care under the Pennsylvania Medicaid program. Temple is the plaintiff in an action challenging the compliance of Pennsylvania’s Medicaid rate system with the federal Medicaid statute. *Temple Uni-*

¹Temple is a Pennsylvania non-profit corporation which has been legislatively designated as state-related but which operates independently of state government under the direction of its board of trustees. 24 Pa. Cons. Stat. Ann. §§ 2510-1 *et seq.* (Purdon Supp. 1989).

versity—Of the Commonwealth System of Higher Education v. White, et al., Civ. No. 88-6646 (E.D. Pa.)

This amicus brief will not discuss the legal precedents applicable to this matter but rather describe the situation of inner city hospitals and the effect this Court's decision will have on them and the indigent communities they serve.

Temple University Hospital is the primary hospital for Temple's School of Medicine and provides a training ground for students, residents and fellows and a range of tertiary care to patients who are drawn to the hospital by the excellent reputation of its faculty physicians. Temple University Hospital also serves an area of North Philadelphia with a substantial indigent population which is largely black and Hispanic. The last census revealed that the neighborhoods around Temple University Hospital have poverty rates of between twenty-four percent and fifty-one percent. The residents of these neighborhoods have many and critical needs for medical services. For example, the infant mortality rate in these neighborhoods is among the highest in the United States, more than twice the national average. Seventy-two percent of the women giving birth are unmarried. Twenty percent of the babies born at Temple University Hospital are cocaine-addicted at birth and sixty percent suffer from low birth weight or other problems. An increasing percentage of newborns has syphilis or gonorrhea. Temple University Hospital provides the sophisticated obstetrical and neonatal care that these patients require.

About half of the inpatient admissions at Temple University Hospital are eligible for Medicaid, another

twenty percent (also largely indigent) are covered by Medicare and five percent have no source of payment at all. The Temple University Hospital emergency room acts as the family physician for thousands of indigents because of the shortage of physicians in the surrounding neighborhoods. Temple University Hospital is heavily dependent on the adequacy of Medicaid payments.²

Temple University Hospital is also in serious financial difficulty. It expects to lose about \$15 million during its current fiscal year. Of this amount, at least \$12 million will be as the result of care provided to medical assistance inpatients.³ The remainder of the loss will result from treating Medicaid assistance outpatients and treating indigent inpatients and outpatients who do not qualify for Medicaid but cannot afford hospital care.

Congress has found that hospitals that serve large numbers of indigent patients usually have higher costs. Statistical studies offered by Temple at trial support this conclusion. Notwithstanding the fact that Temple

²Congress was concerned about the hospitals like Temple University Hospital: "The conferees recognize that public hospitals and teaching hospitals which serve a large Medicaid and low income population are particularly dependent on Medicaid reimbursement and are concerned that a State take into account the special situation that exists in these institutions in developing their rates." H.R. Conf. Rep. No. 208, 97th Cong., 1st Sess. at 962, reprinted in 1981 U.S. Code Cong. & Ad. News 1324.

³Pennsylvania pays for inpatient care by classifying the 229 general hospitals in the Commonwealth into seven groups and paying all hospitals in each group at the same rate. That rate is, by the Commonwealth's calculation, 14% below the average cost per case of the hospitals in each group. Temple University Hospital's group includes not only the six Philadelphia medical school hospitals, but Pittsburgh hospitals, Philadelphia hospitals affiliated with medical schools, Philadelphia community hospitals, Philadelphia suburban hospitals and two rural teaching hospitals. Thus, although Temple University Hospital is the average cost hospital in this diverse group, it is paid substantially less than its costs.

University Hospital has the largest number and percentage of Medicaid patients of the six medical school hospitals in Philadelphia,⁴ it is, by ten percent, the least expensive of those hospitals. Temple University Hospital has achieved this position by cutting its costs substantially in recent years. It cannot continue to reduce costs without adversely affecting the quality or scope of care.⁵

To survive, Temple University Hospital needs additional revenue. Because Pennsylvania's Medicaid payments do not comply with the federal Medicaid statute, Temple filed an action in federal court in August of 1988 seeking injunctive relief against the officials responsible for the Pennsylvania Medicaid program. Temple's action is a systemic challenge which, if successful, would benefit all hospitals in the Commonwealth. Temple maintains that Pennsylvania's rates for inpatient hospital care violate federal law because they are not "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" and do not adequately "take into account the situation of hospitals which serve a disproportionate

⁴Temple's choice of hospitals with which to compare itself is consistent with Congressional recognition "that facilities that provide teaching services or other specialized tertiary care services . . . may have operating costs which exceed those of a community hospital." H.R. Rep. No. 158, 97th Cong., 1st Sess., Vol II at 294 (1981).

⁵The ability of an inner city hospital to cut costs is limited by many factors, including the need to comply with national accreditation standards and comprehensive state regulations, the need to offer better than competitive salaries to persuade personnel to work in the inner city, the need for additional security and parking, the need to offer high quality services to attract higher paying patients to offset losses from Medicaid patients, and the need to provide the extra services required by indigent patients.

number of low income patients with special needs." 42 U.S.C. §§ 1396a(a)(13)(A) (1982 & Supp. V 1987), 42 U.S.C.A. § 1396r-4 (West Supp. 1989).

Temple's principal claims are the following:

1. Pennsylvania has established payment rates for inpatient hospital care without any reasoned analysis of the costs of economically and efficiently operated hospital. Rather, the level of the rates has been dictated annually by the Governor's Budget Secretary as that necessary to achieve the Governor's budgetary objectives.
2. Pennsylvania rates are sufficient to pay the costs of only about seventeen percent of the hospitals in the Commonwealth. The payments to those Philadelphia medical school hospitals that provide the largest volume of indigent care are not high enough to meet costs, no matter how efficiently those hospitals operate.
3. Pennsylvania has responded to the 1987 Congressional directive to make additional payments to those hospitals which serve a "disproportionate number of low income patients" by making the smallest additional payments that it thought it could get away with. Pennsylvania has made no reasoned analysis of the additional costs of the hospitals receiving those payments.

Temple's action was tried in June of 1989 and is awaiting decision. Temple's action may depend on this Court's resolution of this matter.⁶

⁶Temple's complaint also alleges jurisdiction under 28 U.S.C. § 1331 (1982), which jurisdiction is not directly before this Court. Temple's complaint also alleges that Medicaid rates do not adequately take into account the situation of "disproportionate share" hospitals (42 U.S.C. § 1396a(a)(13)(A) (1982 & Supp. V 1987), a claim not made by respondent Virginia Hospital Association.

SUMMARY OF ARGUMENT

In many states, the burden of providing the major portion of the medical care to Medicaid recipients falls heavily on a small number of inner city hospitals. Medicaid recipients are heavily dependent on these hospitals for their care and the hospitals, in turn, are heavily dependent upon the adequacy of Medicaid payments.

If State Medicaid rates are not "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" as required by the federal Medicaid statute, an action in federal court is the only remedy for these hospitals. Federal administrative review of State Medicaid rates is perfunctory. States need not permit hospitals to challenge the State's own compliance with federal law as part of State administrative remedies.

Inner city hospitals cannot continue to operate without participating in the Medicaid program. If Medicaid payments are inadequate, the hospitals' only solutions are to close or declare bankruptcy.

Congress required that State Medicaid payments be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." While that standard gives States greater latitude in setting rates than prior law, it also imposes limitations which Congress intended to be met to assure quality care for Medicaid patients. An action by hospitals in federal court is the appropriate enforcement mechanism.

ARGUMENT

1. A FEDERAL COURT LAWSUIT IS A HOSPITAL'S ONLY REMEDY FOR INADEQUATE MEDICAID PAYMENT RATES.

Neither review of state Medicaid plans by the federal Department of Health and Human Services nor state administrative procedures afford Medicaid providers an adequate remedy for legally insufficient Medicaid payment rates.

A. The Secretary of Health and Human Services Does Not Review the Adequacy of Medicaid Rates.

The federal Medicaid regulations require states participating in the Medicaid program to submit Medical Assistance Plans to the Secretary of Health and Human Services and to give annual assurances and make findings that the rates are "reasonable and adequate". The Secretary, however, believes that the Medicaid statute "does not require him to analyze or verify the State's findings, but only to satisfy himself that there is a reasonable basis on which the State's assurances may be accepted." Brief of Amicus United States at 21.

In actual practice the Secretary undertakes no review at all. An HHS official has testified in Pennsylvania that HHS practice is not to "look behind" the assurances given by any State. See Testimony of Peter Goodman, cited in support of Finding 201 of the District Court in *West Virginia University Hospitals, Inc. v. Casey*, 701 F. Supp. 496, 510 (M.D. Pa. 1988). Possible review by the Secretary of HHS does not provide hospitals with an effective remedy for inadequate payment rates.

B. State Administrative Procedures Do Not Provide Hospitals With a Remedy for Inadequate Medicaid Rates.

Federal regulations require participating States to institute an appeals procedure by which providers can challenge their payment rates:

Provider appeals. The Medicaid agency must provide an appeals or exception procedure that allows individual providers an opportunity to submit additional evidence and receive prompt administrative review, with respect to such issues as the agency determines appropriate, of payment rates.

42 C.F.R. § 447.253(c)(1987). The State Medicaid agency can determine what issues are appropriate for review and need not include as such an issue the compliance of its rate system with the federal Medicaid statute. The State Medicaid agency is not even required to permit judicial review of its determination of any appeal. 48 Fed. Reg. 56,046, 56,052 (December 19, 1983). Appeals or exceptions under this regulation, therefore, do not afford providers with a remedy to redress a State's failure to comply with the federal Medicaid statute.

II. AN INNER CITY HOSPITAL CANNOT WITHDRAW FROM THE MEDICAID PROGRAM.

If Medicaid payments are inadequate for their needs, the inner city hospitals who bear the principal burden of providing medical care to the indigent cannot withdraw from the Medicaid program.

Amici States of Connecticut et al., at pages 2-3, argue that health care providers are not the intended benefi-

ciaries of the Medicaid program but are business entities that have made the voluntary business decision to enter the Medicaid program, much like the construction companies that build elementary schools. The amici argue that, if a health care provider is dissatisfied with Medicaid rates, his remedy is to withdraw from the program. This argument ignores the locations as well as the legal and social obligations of inner city hospitals that provide the largest portion of Medicaid services.

To begin with, many inner city hospitals have received Hill-Burton funds. Regulations promulgated in 1979 by the Secretary of Health and Human Services require any hospital that has ever received federal construction assistance under the Hill-Burton program to participate in the Medicaid program. 42 C.F.R. § 124.603(c)(1)(ii) (1979). Federal courts have upheld the application of this requirement even to those hospitals that received construction assistance prior to its promulgation. *American Hospital Association v. Schweiker*, 529 F. Supp. 1283 (N.D. Ill. 1982), *aff'd*, 721 F.2d 170 (7th Cir. 1983), *cert. denied*, 466 U.S. 958 (1984). Thus, no inner city hospital which has received Hill-Burton funds could exercise the option to withdraw from the Medicaid program even if there were no other restrictions.

Even if they have never received Hill-Burton funds, hospitals cannot choose not to participate in the Medicaid program the way that construction companies can decline to build schools. Construction companies have mobile equipment and personnel which move from jobsite to jobsite. In contrast, hospitals provide services from fixed locations and draw patients from the sur-

rounding neighborhoods. As a result, the burden of Medicaid patients is unevenly distributed. Rural and suburban hospitals typically serve relatively small numbers of Medicaid patients; inner city hospitals serve large numbers.⁷

Serving Medicaid patients is not only the regular function of inner city hospitals; in many cases it is legally required. Regulations of the Pennsylvania Department of Health require a hospital to provide emergency room services consistent with the scope of that hospital's services. 28 Pa. Code §§ 117.12, 117.13 (1981). Police and fire departments bring large numbers of patients to hospital emergency rooms. Under both federal and state law, a hospital must accept and treat any patient who needs emergency treatment.⁸ Thus, as a result of federal and state law and municipal practice, inner city hospitals receive large numbers of indigent patients whom they are required to treat. If an inner city hospital withdrew from the Medicaid program, it

⁷The average hospital in Pennsylvania had 13% Medicaid occupancy in 1986-1987. Nine hospitals were more than two standard deviations above that statewide mean. Eight of those hospitals, with Medicaid occupancy percentages of up to 85%, serve North Philadelphia; the ninth serves a largely indigent black neighborhood in West Philadelphia. Similarly, the average Pennsylvania hospital had 7194 Medicaid inpatient days. Seven hospitals, all in Philadelphia, had more than 40,000 such days and provided over 19% of the care given by 229 general hospitals.

⁸Federal law requires any hospital which has an emergency room and participates in the Medicare program to accept any patient with an emergency medical condition or in active labor, and to screen and stabilize that patient before transferring him or her to another facility. 42 U.S.C. § 1395dd (Supp. V 1987) Pennsylvania state regulations include a similar requirement. 28 Pa. Code § 117.13 (1981).

would be compelled to treat large numbers of patients without any compensation whatsoever.⁹

These legal requirements reflect the expectation of society that non-profit charitable hospitals are not business entities but service organizations for the communities in which they are located. An inner city hospital can attempt to expand its market and to draw patients from beyond its immediate neighborhood for specialized treatments for which it has particular capabilities.¹⁰ Treatment of these patients may generate surplus revenues which can be used to partially offset losses from the treatment of indigent patients. However, an inner city hospital cannot remain open while turning its back on the community in which it is located. Regardless of legal requirements, the community would not permit the hospital to refuse to treat indigent patients.

In summary, an inner city hospital that cannot survive on the payments it receives under the Medicaid program (and whatever other sources of revenue it may have) cannot withdraw and serve a different patient population. If Medicaid payments are insufficient, the hospital can only declare bankruptcy or close.¹¹

⁹Many of these emergency room admissions are not eligible for Medicaid but are still unable to pay for hospital care. Inner city hospitals care for these patients without any payment.

¹⁰The ability of a hospital to do this would be limited, in many states, by its ability to obtain approval under certificate of need laws for capital expenditures and additional services.

¹¹In the last two years, three hospitals serving North Philadelphia have filed for protection under the federal bankruptcy laws. Three more, including Temple University Hospital, are in serious financial difficulty. If Temple University Hospital were to close, there would be a serious shortage of hospital services in North Philadelphia. As recently as November 28, 1989, a hospital in South Philadelphia announced that it was closing because of inadequate Medicaid and Medicare payments.

III. A FEDERAL CAUSE OF ACTION FOR HOSPITALS IS NECESSARY TO ACHIEVE THE CONGRESSIONAL PURPOSE

In requiring that Medicaid payments be "reasonable and adequate" to meet hospital costs, Congress gave both freedom and direction to the States. On the one hand Congress intended to give significant discretion to States in setting payment rates. The Courts have responded by holding that the "reasonable and adequate" standard is not a precise number but a range. *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11, 26 (3d Cir. 1989); *Colorado Health Care Association v. Colorado Department of Social Services*, 842 F.2d 1158, 1167 (10th Cir. 1988); *Wisconsin Hospital Association v. Reivitz*, 733 F.2d 1226, 1233 (7th Cir. 1984). The Courts have not engaged in an independent determination of what the Medicaid rates should be and have declared them not to be "reasonable and adequate" to meet hospital costs only if they were arbitrary and capricious. *West Virginia University Hospitals, Inc. v. Casey*, 885 F.2d 11, 24 (3d Cir. 1989); *Mississippi Hospital Association v. Heckler*, 701 F.2d 511, 516 (5th Cir. 1983).

On the other hand, Congress did not intend to give States a license to do whatever they pleased. Congress was clear that a State should not "develop rates . . . solely on the basis of budgetary appropriations." H.R. Conf. Rep. No. 1479, 96th Cong., 2d Sess. at 154, reprinted in 1980 U.S. Code Cong. & Ad. News 5944. The Senate stressed that "[t]he flexibility given the States is not intended to encourage arbitrary reductions in payments that would adversely affect the quality of

care." S. Rep. No. 139, 97th Cong., 1st Sess. at 478, reprinted in 1981 U.S. Code Cong. & Ad. News 744. As the Secretary of Health and Human Services has stated as to nursing homes:

If facilities are underpaid, because a State's flat rate is unrealistically low or because in determining its rate, the State refuses to recognize as allowable costs some of the real costs of providing services, facilities will be under pressure to cut corners and provide lower quality care or will be forced to make their non-medicaid patients absorb some of the costs of Medicaid patients' care; at worst, facilities may refuse to accept Medicaid patients.

41 Fed. Reg. 27,300 (July 1, 1976).

If Medicaid rates are not "reasonable and adequate" to pay hospital costs, the inner city hospitals that treat the largest portion of the Medicaid patients cannot make up the difference by charging more to non-medicaid patients. Nor can they refuse to admit Medicaid patients. They can only cut corners, reduce services, and incur losses. If Medicaid patients are to receive quality care, as Congress intended, these inner city hospitals must have an effective remedy. The hospitals are immediately and directly affected by the inadequacy of State Medicaid rates to pay hospital costs.

Patients are not immediately and directly affected by violation of this requirement. They have no knowledge of hospital costs, Medicaid payment rates, or, in many cases, hospital standards of care. Federal regulations require that the hospital send the bill to the State, accept the Medicaid payment as payment in full, and not seek additional payment from the patient. 42

C.F.R. § 447.15 (1985). As a result, patients are admitted, treated, and discharged without knowing how much the hospital is paid for their treatment. Patients cannot be expected to enforce a legal requirement when they are not privy to the facts which would cause the requirement not to be met.

The federal Medicaid statute requires that rates be "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." Only if that requirement is met can Medicaid recipients, particularly those in inner city neighborhoods like those surrounding Temple University Hospital, receive the quality of care that Congress intended and that their critical health needs require.

State governments understandably want to minimize their expenditures. If the Congressional purpose of assuring quality care to Medicaid recipients is to be achieved, decisions by those governments on what rates are "reasonable and adequate" must be subject to impartial review at the behest of those entities most immediately and directly affected. This can only be accomplished through an action by a provider in federal court. Because of the latitude inherent in the "reasonable and adequate" standard, and the deference given by Courts to the State rate-setting decisions, providers should be expected to sue only in extreme circumstances and States which have acted responsibly should have little to fear.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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